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UNIVERSITY OF ALBERTA

PRIVACY ATTAINMENT AND MAINTENANCE FOR A LONG-TERM CARE RESIDENT

BY

MARY LYNN APPLEGATE

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

FALL 1990

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PRIVACY ATTAINMENT AND MAINTENANCE FOR A LONG-TERM CARE RESIDENT

SUBMITTED BY MARY LYNN APPLEGATE

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF NURSING.

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Date: August 7/90

Dedicated to Mom

Mrs Myrtle Applegate

1908-1989

ABSTRACT

In this study, privacy attainment and maintenance is examined in a long-term care facility. Although it has been reported in the literature that the need for privacy maintenance is essential, it is unclear how this is achieved when the resident has minimal control over basic daily activities. In order to address privacy attainment and maintenance for the long-term care resident, the method of interpretative ethnography was used. Participant observation and interviews were done over a six month period at a long-term care facility.

The findings of this study indicate that respect for the individuality of the person was an antecedent of respecting privacy. Interactions between staff and residents could be classified in three different ways, personalized, depersonalized and dehumanized. When the interaction was personalized, staff and residents acknowledged the uniqueness of each other. As there was a respect for the person as an individual, respect for privacy was inherent in this relationship. When the interactions were depersonalized, the relationship no longer reflected an appreciation of the person but was structured by the social context of the institution. The relationship showed the characteristics of people who were strangers. Respect for privacy at this level was mechanical with ascribed rules and expectations directing privacy maintenance. When the interactions were dehumanized, residents and staff treated each other as if they were invisible or were objects. Interactions that did occur were task based. Privacy norms were largely ignored at this level.

To assist residents to attain and maintain privacy it is necessary that staff and residents acknowledge the personhood of each other. Such a process is facilitated when it is reciprocal. Therefore the responsibility, when possible, should be shared by both staff members and residents. Yet many of the accepted norms of

institutionalization work against building relationships between residents and between residents and staff member. A respect for privacy is a respect for the uniqueness of each other and this can only be appreciated when residents and staff know each other beyond the caregiver role.

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Although doing this thesis was at times a tedious and joyless experience, memorable occasions associated with it did occur. One blustery winter evening when I was sure all was for naught as far as the data, my thesis supervisor, Dr Jan Morse, after listening to me describe my data, was able to exercise her creative mind and put it all into a context that ultimately led to my findings about privacy. I appreciate the opportunity of working with Dr Morse. I am also appreciative of the support and suggestions of my two committee members, Dr. Darle Forrest and Dr. Jan Storch.

Without the support of my colleagues in the office and friends here and in Prince George, I would have perished early.

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I. INTRODUCTION

*What a disgrace to be seen crying by that fat Doris. The door of my room has no lock. They say it is because I might be taken ill in the night, and then how could they get in to tend me (**tend**—as though I were a crop, a cash crop). So they may enter my room any time they choose. Privacy is a privilege not granted to the aged or the young. . . . It's because neither are human to the middling ones, those in their prime, as they say, like beef.*

Laurence (1967).

Respect for an individual's privacy is minimally considered as a moral obligation and in some situations it is considered a legal requirement. Yet, as Hagar lamented (Laurence, 1964), for some individuals who become dependent on others, privacy becomes a lost prerogative.

Privacy allows for a feeling of personal control and the expression of autonomy; an opportunity for quiet reflection and self-evaluation; a release from societal expectation and the situational context for the sharing of personal information (Westin, 1967). Privacy is a concept identified in all cultures (Altman, 1977; Gregor, 1970, 1974) and is considered necessary for attainment of mental and physical health (Schultz, 1977). Although the need for privacy is universal, personal and environmental factors affect the way privacy is perceived and sought. For an individual institutionalized with physical or mental impairments, previously learned ways of safe-guarding privacy may no longer be possible. In addition, health care workers in the performance of care often must invade private areas, both physical and informational, previously considered solely within the individual's domain.

Statement of the Problem

Although it has been reported in the nursing literature that the need for privacy maintenance is essential, it is unclear how this is achieved when the resident has only minimal control over basic daily activities. Further, potential discrepancies between staff and residents' perception of what is private to the resident may also influence residents' privacy and makes assessment of privacy a difficult task if not impossible. There is a need for information on the maintenance of privacy by individuals who depend on others for care within the restricted institutional environment.

Importance of Privacy and Institutionalization

A common complaint of patients entering care institutions is that there is no opportunity to maintain privacy. Many circumstances of institutionalization would appear to make privacy maintenance difficult if not impossible. The very nature of the relationship between staff members and residents may require that staff members assume the responsibility for intimate functions usually done independently by adults. As well, care activities in institutions are often carried out in areas shared with other residents on the ward (e.g., a common shower and tub room). The legal implications of supervising residents even in self-care activities require staff to have easy access to resident rooms and communal areas. As a result there has been a passive resignation that actions to protect privacy, although important, are often incompatible with the role of caregiver. The invasion of privacy by clerical staff, health care workers and even by other patients is considered stressful at a time when the ill and dependent person is least able to cope. Considering the stresses associated with illness and institutionalization, the benefits of supporting privacy maintenance ease day-to-day living for the resident.

Purpose and Rationale

Loss of privacy is not only an infringement of the rights of the residents but may have deleterious effects on health. To fully respect residents' rights, caregivers must recognize behaviors employed by individuals to attain and maintain privacy. The implementation of prescriptive rules for privacy protection, such as pulling curtains and positioning drapes, do little to alleviate the reality of privacy invasion.

Therefore, the purpose of this study was to identify and describe privacy attainment and maintenance by residents in a long-term care facility. The two main questions addressed in this study included:

1. What strategies do residents use to attain and/or maintain privacy in a long-term care facility?

2. What influence does the setting (including the physical and human characteristics) have on privacy attainment and maintenance?

II. LITERATURE REVIEW

It was suggested a century ago, that as a society increases its standard of living, matters related to privacy become more of a concern (Warren & Brandeis, 1890). The deluge of descriptive literature on the topic which emerged from writers in the social sciences, philosophy and law since the 1950's indicate an increased interest in this topic. Although the number of non-investigative descriptive articles has increased, there have been relatively few research-based studies. The literature has focused extensively on the meaning and dimensions of privacy and the legal and philosophical implications of each viewpoint.

Meaning of Privacy

The variety of definitions of the concept of privacy found in the literature reflect a lack of agreement regarding the essential nature of this concept. The word privacy is derived from the Latin word *privatus*, meaning withdrawn or apart from public; peculiar to oneself; or belonging to an individual (Hoad, 1986). It has been described as a feeling (Bates, 1964); a right (Westin, 1967); a state (Boone, 1983; Kelvin, 1973); or a freedom (Halmos, 1953). Other writers suggest that privacy can be conceptualized as a process of control, but there exists disagreement whether the control is over personal transactions (Margulis, 1977); over access to self (Altman, 1975); or over personal information related to one's identity. These control definitions have been criticized because they define the process of attaining privacy rather than the entity of privacy *per se* (Garrett, 1974). However, these definitions are useful in establishing moral or legalistic claims to privacy (Greenwalt, 1974, p. 46) as well as providing a conceptual basis for identifying behaviors associated with privacy maintenance.

Much of the discussion of privacy has debated the question whether it is a right on its own merit or whether it is derived from other interests (Benn, 1971; Brandeis, 1964/1984; Gross, 1971; Prosser, 1960/1984; Simmel, 1971; Warren & Brandeis, 1890). Human dignity and the autonomous nature of humans are an inherent part in many of these discussions of privacy. Privacy has also been supported for the important role it plays in the development and maintenance of the sense of self (Reiman, 1976). The right to privacy may also reflect the practical importance it serves of "providing the rational context" for the development of significant relationships of love trust and friendship (Beardsley, 1971; Fried, 1970/1980). The ability to selectively disclose information that reveals the real self is instrumental in the development of relationships.

Types of Privacy

Solitude, anonymity, intimacy and reserve are four main states of privacy originally identified by Westin (1967). Researchers in the social sciences used these states to further elaborate on the various types of privacy (Marshall, 1974; Pedersen, 1979, 1982).

Solitude is the ability to physically withdraw and be alone. Solitude allows the individual to be free from observation by other persons. In one study, nursing home residents unanimously selected solitude or aloneness as the definition for privacy (Roosa, 1981). Roosa speculated that this was due to the loss of private space inherent in institutionalization.

Others achieve a sense of privacy under the guise of *anonymity*. An individual may be in a public place or performing a public act but seeks and finds freedom from identification and surveillance by not disclosing his/her identity. Although not alone

physically, the behavior is known only to strangers. There is a separation of their social identity and the action.

Intimacy is the third type of privacy identified. With intimacy, access to self is restricted on a social dimension to family or friends. Pedersen (1979) found that intimacy with friends was an entity distinct from intimacy with family. In either case intimacy allows for the development of a relaxed and frank relationship with others by exercising corporate seclusion of others (Westin, 1967).

When physical distancing is impossible, psychological withdrawal or non-participation known as *reserve* may be used (Henderson, 1975; Schuster, 1972; Schwartz, 1968; Westin, 1967). Reserve creates a psychological barrier against unwanted intrusion. With reserve, an individual is able to exercise control over self-disclosure by simple non-participation in an interaction. Restrictions to mobility often make this form of privacy the only option available to institutionalized individuals. Although these types of privacy capture the physical, social and psychological aspects of privacy, the informational dimension that is central to confidentiality is missing.

Descriptive Aspects of Privacy

Several first-person descriptions of family and patient experiences in the health care system portrayed the emotional trauma associated with invasion of privacy. (Brown, 1978; Crook, 1977; Farrant, 1983; Preston, 1988; Waskett, 1974). These accounts illustrated many aspects of privacy. Although invasion of bodily privacy such as exposure during bathing and elimination were described, losses that destroyed a sense of identity were a more important aspect of privacy in these accounts. The sense of identity included their name and possessions but also the right to make personal decisions related to their life style and care, including even the right to die. There was a

veiled criticism of those care-givers who interacted with patients on a "professional" level while avoiding the reality of the patient's situation.

Variables Affecting Privacy Attainment and Maintenance

Physical, psychological and social circumstances affect how an individual perceives and pursues privacy. Privacy values, beliefs and behaviors are culturally derived (Hall, 1969). Although norms are established by the dominant culture, considerable individual variation occurs. Specific role expectations related to privacy behaviors are intrinsic to the patient role (Schuster,1972). Norms related to privacy in a long-term care facility may reflect more the values and beliefs of those responsible for providing thorough and efficient care than those of the resident.

In the nursing literature, considerable attention has been given to the concepts of personal space and territoriality (Allekian, 1973; Cooper, 1981; Esberger, 1982; Giorella, 1980; Hayter, 1981; Johnson, 1979; Louis, 1981; Meisenhelder, 1982; Minckley, 1968; Plucklan, 1968; Roberts, 1978; Stillman, 1978; Tate, 1980). Territoriality has been closely linked to privacy but the exact relationship is not clear. Edney and Buda (1976) noted that different functions were served by territoriality and privacy. The former provided a sense of identity and the latter a feeling of freedom and creativity.

Two descriptions of the relationship between territoriality and privacy have been suggested. In the first, territoriality is described as privacy-seeking behavior (Altman, 1975; Proshansky, Ittelson & Rivlin, 1976). In the second, privacy is viewed as the link between territoriality and the achievement of a sense of autonomy (Pastalan, 1970). In an institutional setting, residents who are able to claim a physical space as their own (territoriality) are better able to achieve a feeling of privacy (Altman, 1975; Pastalan, 1970; Proshansky, Ittelson & Rivlin, 1976). To view privacy as a function of

territoriality makes privacy dependent upon the resident's ability to claim an area as his/her own. Because privacy has a psychological dimension, physical separateness need not be present for privacy to be attained. Thus, while territoriality may facilitate a feeling of privacy, it is not a consistent pre-requisite for privacy.

Privacy Related Behaviors

Due to the lack of consensus regarding the definition of privacy, few studies have been done to identify specific privacy behaviors. Much of the research has focused on territoriality and personal space protection rather than privacy maintenance. A study which provided a limited examination of privacy-seeking behaviors in public places was done by Henderson (1975). She observed that body positioning and the use of props (e.g. a book) created psychological barriers that prevented unwelcomed friendliness or interactions in a bus terminal.

A more in-depth examination of how patients maintained privacy was done by Schuster (1972). This researcher used a phenomenological approach to examine the nature of privacy and identified behaviors that patients used in the hospital to promote interpersonal distancing, such as the use of physical separation of closing a door or drawing a curtain. An even more obvious form of privacy-seeking behavior was deliberate physical withdrawal from a situation. Body positioning, facial expressions, inattentiveness, or creating physical barriers were methods that were used in acute care patients to promote interpersonal distancing. For the long-term care resident with impaired mobility, it would appear that the ability to withdraw psychologically in a public place and therefore ignore surrounding activity is often the only available privacy-maintaining behaviour.

III. METHODS

The purpose of the study and the research questions determine the type of methods to be used in the study (Field & Morse, 1985; Reinhardt & Cook, 1979). The purpose of this study was to describe privacy attainment and maintenance for residents in a long-term care facility. Previous research concerning privacy has focused on definition, interpersonal distancing, personal space requirements and external influences. These studies have provided a better understanding of aspects of privacy and in some cases provided practical direction for privacy protection in the form of rules and admonitions. By using a qualitative, inductive approach the researcher attempted to expand the present understanding of privacy and to capture a broader perspective of privacy. A qualitative approach allowed the researcher to study both the interaction of all the players in the setting as well as with the setting itself thus capturing those environmental factors that influence the resident's privacy. This chapter represents a discussion of the methods used to describe privacy attainment and maintenance in a long-term care facility.

Interpretative Ethnography

A qualitative method allows the researcher to describe patterns of behavior and processes of interaction as they occur in a natural setting. Although written about extensively in non-investigative descriptive literature, variables involved in privacy protection have not been adequately described. The qualitative research method adopted for this study was interpretative ethnography. This approach employs participant observation and unstructured interviewing to study the phenomena of interest in the natural setting from the subject's point of view. Ethnography is the systematic collection, description, and analysis of data to develop concepts to

understand a particular way of life (Aamodt, 1982; Field and Morse, 1985; Germain, 1986). Interpretative ethnography allows the researcher to not only describe the behaviors associated with the phenomena of interest but also to ask "what it is that in their occurrence and through their agency, is getting said" (Geertz, 1973, p.10). It provides some insight into a fragment of human experience (Sperber, 1982, p.21).

Choice of the Setting

This study was conducted in a long-term care facility where there were residents with a variety of mental and physical impairments. It was assumed that residents would be required to make adjustments in their usual ways of privacy protection due to institutionalization.

The study took place in a veteran's extended care facility in Canada. The data collection for the study took place over a six-month period from September, 1989 to March, 1990.

Selection of the Participants

As the subculture of a long-term care facility was being studied, it was important that all individuals who were involved in ward activities were included in the observations. Key informants were chosen from among the mentally competent residents. Secondary informants were chosen to confirm observations and to give feedback on the analysis. Residents and unit staff were used as secondary informants.

An overview of the study was presented to the head of patient services and informal support for the study was obtained. Official approval to conduct the study was obtained from the institution. The study was presented to the nurses and care attendants at a staff meeting and a copy of the proposal for the study was made

available on the ward for the staff to read. The study was presented to the resident council committee and received support prior to the researcher initiating the project.

All competent residents and staff who agreed to participate and all incompetent residents were included in the participant observation aspect of the study. During the participant observation period, informal conversations and observations provided much of the data for analysis. Five residents were interviewed to describe their life on the unit. These were key informants who were assessed to be "culture bearers". They appeared to be a part of the scene and would be able to provide the researcher with descriptive material of life in the facility. They were used to validate perceptions of the unit. The men were selected for their potential to enrich the data and to expand the researcher's perspective of the total reality of the setting. Three of these men were interviewed once and two were interviewed twice. One resident, a care aide and a registered nurse were interviewed as secondary informants. Because data analysis occurred concurrent to data collection, ideas were frequently discussed with both staff and residents during participant observation. Several support staff workers were interviewed to obtain information about their role in the setting.

Ethical Concerns

The research proposal received ethical clearance from the nursing faculty ethics committee, the hospital ethics committee and the medical ethics committee. All mentally competent residents and all staff from the area were asked to participate in the study. A letter introducing the study was delivered to all competent residents by the staff the evening before the researcher began approaching the residents to sign a written consent (Appendix A). The mental status of the residents was assessed by the nursing staff. Nonconfused residents were given the letter of explanation by the nursing staff on the unit prior to the researcher approaching the resident. The researcher met with each

resident to explain the study and ask for a written consent to participate (Appendix B). Residents unable to sign a consent due to physical impairment were asked to make a mark witnessed by a staff member. A taped verbal consent was also obtained from each of the residents interviewed as key informants (Appendix C).

Approximately half the residents in the unit were designated as mentally incompetent to legally agree to the study. For these residents, notification of the study was sent to the appointed public guardian or the provincial public guardian (Appendix E). Families of all residents received a letter explaining the study from the director of the facility (Appendix D). As well, two notices explaining the presence of the researcher were posted in the facility.

Two residents refused to participate in the study and their decisions were respected. Occasionally interactions with these residents were unavoidable but no information provided by these two residents was used without their verbal consent. Throughout the study the researcher reminded residents of her role and ongoing verbal agreement was frequently obtained. Written consent was obtained from all unit staff who participated in the study (Appendix F). All staff member agreed to participate in the study.

Data Collection Procedures

In ethnography, the researcher is the major instrument for data collection. It is within the context of her participation in the events of the setting that observations of the interactions and activities that occur there are made. Her observations combine with the reports of informants to form the basis for the data analysis. The researcher looks for connections, patterns, themes, or relationships that have meaning to the people in the setting. The research methods consisted of participant observation and unstructured interviewing.

Participant observation.

Non-participant observation allowed the researcher to observe the setting and resident activity from the perspective of those within the setting. The researcher was minimally involved in actual care activity. Her participation was mostly to assist with bedmaking and at mealtime. On the ward brief hand-written notes were made and later these were expanded into field-notes. All observations and informal interactions were recorded in the field notes. Personal subjective feelings, impressions and hunches were recorded in a separate diary. Observations were made from a variety of settings in the facility: sunrooms, coffee shop, arts and crafts room, desk area, front hallway, dining room, and in the corridors, as well as the residents' rooms. During these periods of observation informal conversations with the residents and the staff often took place allowing the researcher to relate her observations to participants and attempt to verify tentative patterns or themes she had identified. The researcher also participated as an observer in regularly scheduled occupational and physical therapy sessions, recreational activities and special events. The staff also included the researcher in their organized events.

Interviewing.

Much of the information was collected through informal conversations with the informants. Interviews with primary informants were guided by the use of broad descriptive open-ended questions (e.g.,."Tell me about a typical day here"). These interviews were conducted to obtain the resident's perspective of life at the facility. The foci of the interviews concentrated on the daily lives of the residents. Prompts were often required, such as asking for descriptions of routines or changes in their lives and care activities. Interviews were conducted either in the resident's room or in an office adjacent to the unit. They were tape recorded and later transcribed for coding. The interview tapes were numerically coded to insure anonymity.

Secondary informant data.

Once data some preliminary codes were established, secondary informants were used to confirm this information. These were approached both formally and informally to verify the analysis. This information was collected from both residents and staff in the setting.

Data Analysis

Data analysis was conducted concurrently with data collection. Gehring (1973) stated that the art and discipline of the researcher in ethnography lies in watching and listening, while trying to inductively derive meaning from the behaviors of others. Observations were recorded daily in the field notes. These observations were analyzed to identify patterns in the data that might provide new insights or understanding of the setting. Once preliminary categories were established, interviews to have the residents describe their experience in the facility were initiated. These were taped recorded and transcribed verbatim. Later these were analyzed for content. Following content analysis, the transcripts were photocopied, cut-up, categorized and organized into separate file folders for storage.

Reliability and Validity

"Reliability of ethnography involves the consistency of both the sources of data, including informants and the researchers, and the methods of data collection" (Germain, 1986, p. 159). To enhance replicability, the physical, social, and interpersonal contexts within which the data were collected need to be described (Le Compte & Goetz, 1982). To increase the reliability of the study the researcher used the following strategies. First, detailed field notes were kept of all observations made in the setting. These included descriptions of the setting and activities, behaviors and

conversations amongst the participants. These were written immediately after each field experience from notes made during the day. Second, interviews were taped recorded to allow verbatim transcriptions to be made of the residents' description of their life in the long-term care facility. Participants' direct quotes were then used to substantiate the study's findings.

The validity of a study depends on its research findings being a "true" representation of reality. In qualitative research, the data are obtained directly from the informants, "unfiltered through concepts, operational definitions, and rating scales" (Taylor & Bogdan, 1984, p. 7). The researcher spent six months in the setting; this allowed her to make observations in a variety of physical and social circumstances. As well, the participants in the study became accustomed to her presence; thus the effect of her presence on the situation was reduced. All observations were carefully recorded in the field notes. From these observations the researcher developed a descriptive picture of life in the long-term care facility. Missing information was gathered on an ongoing basis. The researcher's observations were verified by the active participants in the setting.

The use of unstructured interviews with the key informants allowed the researcher to develop an "insider's" vantage point. Key informants were selected who were knowledgeable about the setting and were able to describe their situation. Three of them had been in the unit for over a year; two were admitted early in the study. One was selected because he was very vocal about the loss of privacy he associated with institutionalization.

As the analysis advanced the research findings were discussed with secondary informants. This was done to ensure that the researcher was accurately representing the "real" situation as understood by participants.s

IV. DESCRIPTION OF THE UNIT

This study was conducted in a Canadian veterans' home which was part of a large health-care complex. Data were collected on one of two 72 bed all male units.

Resident Profile

All residents had been members of the Canadian Armed Forces and had served in active duty overseas. The ages of the men ranged from 64 years to 102 years with 5 men below 65 years of age, 35 men between 65 and 74 years of age, 14 men between 75 and 85 years of age, and 17 men over 85 years old. The men had a variety of physical and mental conditions that resulted in their being institutionalized. Approximately one half of the men were considered mentally competent, and two-thirds of the residents required wheelchairs. Many of the men had a history of alcohol abuse prior to their admission. The level of care required by the residents ranged from minimal to total care, and their length of stay at the facility ranged from newly admitted to 24 years.

Room Description

The unit had 5 private rooms, 17 semi-private rooms, and 8 four bed wards. Toilets were situated between the semi-private rooms which meant that four men shared a single toilet facility. As well, each four bed ward had one toilet facility. Each room had a sink and mirror outside the washroom. Several residents complained that they found it difficult sharing a toilet facility with so many men. There was a call bell intercom by each bed and an emergency bell system in the toilet. There were curtains that could be drawn to separate each bed area. These curtains were usually kept

partially drawn, especially when the resident was lying down. Each resident room had a large window with a built-in blind system.

Each resident had a bedside table and a locker for clothing and personal effects. One drawer in the bedside table could be locked, and the key could be kept by the resident if he requested. A key to the drawer was also kept by the ward staff. Many residents had their own televisions and radios at their bedside, and occasionally, they had other pieces of furniture that were brought in to meet their own specific needs (e.g., overbed tables, recliner chairs, and television stands). The available space in the rooms limited the amount of extra furniture a resident was allowed to bring in. Because of the need to be wheelchair accessible, few rooms had chairs in them. This lack of chairs required visitors in the room to either sit on the bed or stand. Although the researcher asked before sitting on the bed, residents never appeared reluctant or refused this request and often spontaneously invited her to sit there.

The men were encouraged to bring in personal memorabilia to put up in their rooms and pictures of their military service to hang in the corridors of the unit. There was a wide variation in the extent that the rooms were personalized by the men. In some situations, the pictures in the rooms did not appear to be significant to the residents. One man was unable to identify the children in a picture and commented that one of his daughters-in-law had put up that photograph. Other residents demonstrated obvious pride in their pictures, and they would frequently refer to the photographs when discussing their family. Resident rooms were also personalized with bed quilts, comforters, or afghans, which frequently were handmade by family members or bought specifically for the resident.

General Ward Description

The unit was geographically organized into two "teams" of 36 residents each. The majority of mentally incompetent residents were located in one area of team 1. Each team had a sunroom/solarium at the end of the wing corridor. These were furnished with a table, several comfortable armchairs, and sofas. There was also a large screen television in each area. The team 2 sunroom was the only designated smoking area on the unit. The team 1 sunroom was used mainly by the mentally incompetent men and was designated a nonsmoking area.

Doors opening off of the sunrooms led into a central courtyard. It was enclosed by a 1.5 metre fence on which a mural had been painted. During pleasant weather, all of the residents were free to spend time in the courtyard and help with the staff tend the flower gardens. Over the Christmas season, a nativity scene was set up in this area.

The unit desk area was situated between the two teams. The actual desk was approximately 6 metres long and was separated from the corridor area by a 1 metre high panel front. A resident in a wheelchair could just see over the desk. The ward clerk as well as staff members who were involved with the paper work of the unit sat at this desk. Residents' charts were kept at the desk, and three rooms were situated behind the desk area: the medication room, a supply storage room, and the head nurse's office, which also served as the conference room. These three areas were basically staff-only areas and residents seldom entered behind the desk unless they were meeting with the head nurse in her office. Residents waited either in front of the desk or at the open end of the desk when they wished to communicate with the staff. The front panel did not extend to the one end of the front desk and this open space allowed residents in wheelchairs to see across the area.

Each team had a large medication cart that was used to deliver drugs to the residents. The registered nurse assigned to the team would organize the medications in the medication room and then deliver them to the residents.

An open sitting area was situated across from the desk. This area contained several recliner chairs, a table, a television, and a stereo. The windows in this sitting room looked out onto the courtyard, and there was a door leading into it from this area. The staffroom was off of this sitting room. The whole building was designated nonsmoking for staff, and they were required to leave the building to have a cigarette. The most common place for this was just outside the backdoor.

Just away from the desk area was the tub room. This was a large room used for the weekly baths and storage of larger pieces of equipment such as wheelchairs, commodes, and Hoyer lifts. In this room, there were two large Century tubs which could be separated by curtains, a shower (which could be accessed by wheelchair or stretcher), a regular bathtub, and a toilet. Each area could be separated off from the larger room by a curtain. There were built-in shelves that contained the supplies required for the bathing procedure between the two Century tubs. The room had a dark tile floor, and the built-in blinds on the windows were kept closed, which gave the room a dreary appearance.

There were two resident phones on the unit. One was located near the unit desk in a carrell, and one was further away from the desk area. There was also a pay telephone near the front desk.

Handrails were installed along all the hallways, and pictures of the residents from their Armed Forces' days hung along the corridors as well as other pictures associated with military life. There was a full-length mirror at the end of each corridor, and on each team there was a chalk board where the days planned activities were listed. As well, there was a notice board where announcements could be posted to provide

general information. There were two open alcoves just off of the corridors: one was used to store clean laundry, and one contained soiled laundry and garbage. There was also a large hopper on each team which was located by the dirty laundry hampers. On team one, there was a washer and a dryer for the residents' personal use. The office of the clinical educator was located on the unit. Just outside her office, notices of educational programmes pertinent to long-term care were posted. The office was large and could be used as a classroom for educational programmes for unit staff.

Common Areas Off The Unit

The previous description described the geographical areas that were used only by residents from the unit that was studied. The following description is of those areas that were shared by all the residents in the facility.

The physical and occupational therapy departments were located near the unit. There was an occupational therapist, an occupational therapy aide, a physiotherapist, and a physiotherapy aide who were employed fulltime in the facility. The occupational department was equipped with an Apple computer, facilities for cooking, exercise pulleys and ropes, and other aids for activities of daily living. The physiotherapy department was equipped with weighted pulleys, hot packs, a vibrator, *tens*, a stationary bicycle, and parallel bars. There was also a large floor space for the group exercise class. Curtains could be pulled to partition off each treatment area. Programmes were organized to help the residents attain and maintain their maximal level of performance. The offices for each of these departments were just inside the door of each department. Although there was one group exercise class where 8 to 10 residents participated, many of the activities were organized on an individual level. A bulletin board outside each department listed the residents' appointment times.

There was a full kitchen facility that opened into the dining room across a cafeteria-style serving area. Meals were 75% precooked out of the building and then delivered to the facility and reconstituted in the kitchen. Carts containing the meal trays for each resident were situated by the kitchen. The dietician had an office by the kitchen.

There was a large central dining area midway between the two units. Tables for four were positioned in rows across the dining room. The residents sat two by two facing each other. There were few chairs in the room as the majority of the residents were in wheelchairs. There was a cafeteria-style open area at the front of the room for serving the meals. Full-length windows lined the opposite wall opening onto a treed patio area. The room had three large colourful banners on one of the walls and was often seasonally decorated. The floor was covered by a dark brown carpet. In the dining room, there were two large central bulletin boards where the menu for the meal was posted. This room was often used to celebrate special occasions, and at these times, white table cloths would be used.

There was a large room in the center area of the facility that was used by the Red Cross for resident arts and crafts. A large cabinet along one wall displayed the handiwork of the men. There were also individual areas set up for residents with specific hobbies that required space. One man had a table for his oil painting supplies, and another had an area for finishing his woodworking projects. There was also a large loom in the room. Two long tables stretched across the front area of the room, and short tables were located perpendicular to these at the back of the room. These shorter tables were used for many of the craft activities. The room was also used for social events that involved large group gatherings (e.g., bingos, happy hours).

The coffee shop was located by this large room. In the coffee shop, the tables were arranged in order that seven to eight men could sit at one long table, or they could

sit at one of the smaller tables seating two to four men. Ordinarily, nine to ten men occupied the room at any one time, although this varied throughout the day. Chairs in the room were arranged so ambulatory men could sit along the wall leaving the centre open for the residents in wheelchairs. The shop was run by volunteers who were recruited by the recreational department. Occasionally, residents would assist in the coffee shop if volunteers were not available. Coffee, pop, cigarettes, candies, and other confectioneries could be purchased in the coffee shop. Both the arts and crafts room and the coffee shop were designated as smoking areas, and therefore, nonsmoking men often were reluctant to use this area.

There was a smoking lounge near the coffee shop and arts and crafts room. This lounge had approximately ten high-back, upholstered wing chairs and a large screen television set. Blinds on the windows remained closed much of the time in order for the residents to watch television. This gave the room a dark appearance.

The front corridor had full-length windows along the outside wall, and these windows looked onto the main entrance area. During the research data collecting period, construction in the area caused much of the traffic to be diverted away from this roadway, but the activity still provided a point of interest for many of the residents. Small armchairs were arranged in an orderly fashion along this corridor so people could sit and visit either face to face or at right angles to each other. The spacing of the chairs also allowed access to wheelchairs. This area also contained a pool table and shuffle board for resident use. Although the corridor was well-travelled, it tended to be quieter than most common places either on or off the unit. In addition, it was a nonsmoking area.

The front desk of the facility was situated behind a one metre high panel just inside the main entrance. The receptionist was also the cashier responsible for distributing cash to the residents. The main offices for the administrator, secretarial

staff, social worker, recreational director, dietician, and coordinator of patient services were located along the corridor directly beyond the front door. There was also a conference room that was used for smaller organized activities such as Bible studies, facility meetings, and small social gatherings. The conference room served as the zerox room for the facility and as the staff library.

Organization of Ward Staffing

The day shift consisted of a head nurse, an assistant head nurse, two team leaders, and ten aides. During the week, there was also a ward clerk who worked the day shift. Aides were assigned five to ten residents, depending on the amount of required care. On weekends, the staffing consisted of two registered nurses and at least one less care aide. The evening shift had one registered nurse and three aides for each team. The night shift had one registered nurse and two care aides. Whenever there was a shortage of staff, the workloads were readjusted.

A Day in the Life of a Resident

"Life's a damn bore" was the way one resident described life in the facility. Although physically he was able to care for himself, he was admitted to the unit when alcohol abuse made it impossible for his wife to have him at home. He would wake up just before breakfast, and after washing his hands and face, he would make his way to the sunroom for his first half cigarette of the day. By smoking half a cigarette at a time, he was able to restrict his smoking to only half a package a day. This was the first of fifteen or twenty such trips to the sunroom that he made each day. Once he had smoked his cigarette, he would continue on down to the dining room. He did not choose his meals as he found it was "sort of fun to see what the hell they put in front of me each meal." He shared a table with three other residents, and although he would

recognize them at the table, he did not know their names or if they were even from the same unit. They seldom spoke during the meal. Once breakfast was over, he would return to the unit and spend the remainder of the morning moving between the sunroom, where he would smoke a half a cigarette, and his room, where he would lay on his bed. Every 30 to 40 minutes, he would return to the sunroom for a smoke. As he moved down the corridor, he walked with his eyes straight ahead and passed all people with no acknowledgement of their presence. In the sunroom, he seldom communicated with those who shared the space with him. He did not even bother to put in his hearing aid.

Thursday was his "tub day." On this day, once breakfast was over, he would wait in his room for the staff to get him for his bath: "I really enjoy that bath, the staff suds me up and douse me down. It is the first time I have ever had one of those bubbling baths, but it is quite fun." On other days, it was his responsibility to look after his own hygiene; but occasionally, the day would pass, and he would realize he had forgotten to shave or sometimes even to wash. He knew that if this was neglected for more than one day, the staff would remind him to wash.

As lunch time approached, he would return to the dining room and wait for his "feeding." Even if he went five or ten minutes early, there would be others there who had already arrived to wait for their meals. If he was late, someone might have taken his spot. If the resident was eating, he would ask the aide where he should sit; otherwise, he would ask the intruder to move. After lunch, he would have a short nap, but he tried to keep it short so it would not interfere with his sleeping at night.

He spoke warmly of his roommate as a "first class chap," but other than brief conversations related to television, they seldom communicated. The curtain between the two beds remained partially drawn at all times.

He participated in most of the organized activities that were held in the facility. It was a pleasant way to put in a couple of hours each day. He had always enjoyed singing. It was the one time he felt the staff saw him as special. They would compliment his rich baritone voice, appreciating the contribution it made to the singsongs. As well, he enjoyed the bingos and happy hours that were scheduled twice a week. But sometimes these events would be cancelled without notice. The men would sit and wait in vain for the activity to begin. If he asked the staff, they would say it was not their responsibility. It seemed to him that someone should have been responsible to notify the men when an event was cancelled. He refused to attend any of the activities organized away from the building. He felt it would be too painful to return to the facility after a pleasant outing. Maybe in time, but as for now he was adamant that when he left this facility it would be to return to his own house.

He had his own television at his bedside and would watch sports events or the news. He and his roommate tried to cooperate so neither television would interfere with the other. He usually was in bed by 10 pm and sleeping shortly after that, depending on the television programming. He had no real complaints, but he missed the freedom to live his life away from the restrictions of communal living.

Men who were independent started getting up at 5 am or even earlier, and most of the residents were up by their assigned breakfast time. There were five or six residents who wanted to be up before 7 am; therefore, the night staff tried to accommodate them before they went off duty. If any of the mentally incompetent men were awake and restless, the night staff would also get them up. Unless they were sick, all the residents were dressed each day. Residents requiring assistance had their face, hands, and perineal area washed before they were dressed. They were also

encouraged to shave and perform oral hygiene at this time. Occasionally, residents were allowed to sleep in, and their breakfasts were reheated for them later.

After the men were dressed, the mentally incompetent residents who required constant supervision were taken to sunroom 1 or the lounge across from the desk area and seated in chairs. Occasionally, residents who got into trouble when allowed to wander about were restrained in their chairs. These were men who frequently rifled other residents' belongings or persistently got into areas that posed a danger to them. Most of the mentally incompetent men were allowed to wander about the ward. Several residents wore alarm systems which were activated if they left the premises.

There were three sittings for each meal in the dining room. Breakfasts were served at 0730 hours, 0800 hours, and 0830 hours. Each resident was assigned a specific time for their meals. Those men who were up early and were independent with eating were usually assigned the first mealtime. This allowed the day staff to get the other men up. The residents were encouraged to go to the dining room for all meals; however, if it was felt that the stimulation of communal dining was detrimental to the physical or mental well-being of the resident, a meal tray was brought to the ward. When a resident was ill, his meals would be served to him in his room.

Approximately eight residents required assistance with their meals, and six residents required feeding. These men were given their meals either on the ward or in the dining room. Staff were assigned to assist residents in each area. Trays arrived on the unit at 0815, and the ward clerk would announce over the intercom that the trays were at the desk area. Staff then helped distribute the trays and assisted all residents that required help. There were table cloths available on the unit, and these were used by some staff.

There were several methods used for meal planning. Residents were interviewed by the dietician when they were admitted, and whenever there were

concerns related to a resident's dietary intake (such as, loss of weight, change in health status, or complaints about the food). The dietician would plan specific menus based on their histories and/or special restrictions related to their medical conditions. Other residents would fill out a long term menu to be repeated every 28 days. Some men would choose to select their menu each day from the posted menu board in the dining room. Several residents stated that they seldom had a choice about their menu. The dietician felt these men may have forgotten that they had filled out a menu when they were first admitted or else the aides were not giving the men a choice even though it was available.

It was the responsibility of the men who were competent and physically able to get to the dining room on time for their meals. A couple of men would assist in pushing wheelchairs to and from the dining room. Many of the men wore large bibs either over their lap or around their necks to protect their clothes during the meal. For some, it was difficult to secure the bib in place, and one resident often assisted others with this task.

Meal trays were served to the resident by a dietary aide. As a resident arrived at his place in the dining room, the aide would take the man's designated tray from the cart and move along the cafeteria line filling the menu as marked. Alternatively, if the menu was not previously marked, the aide would have to check with the resident for his selection from the board. Two or three staff would go to the dining room to assist residents who required assistance during the third meal sitting.

Between 12 and 14 residents remained on the ward for their meals. Most of these men ate at the table at the desk or else in sunroom 1. Men in sunroom 1 were mentally incompetent and required either feeding or close supervision. Men who ate at the desk were often too physically incapacitated to eat in the large dining room. Most staff would sit and feed residents at a leisurely pace. There were occasions when

residents were fed by large spoonfuls at a rate which made it difficult for them to properly chew and swallow the food. Sometimes family members would bring in a meal for a resident. If it was necessary, these meals would be heated by the kitchen or ward staff.

Reactions to the meals were mixed. Some residents expressed satisfaction with the food and recognized the problems inherent with institutional meals. For others, it was the greatest source of their dissatisfaction with the facility. For these men, it seemed going for meals was a necessary evil. Still other men, although not critical of the food, found it unpleasant eating in the dining room because of the choking and coughing noises.

After breakfast, the baths assigned for the day were started. Each resident had an assigned bath day once a week. Approximately ten men were bathed daily, and one resident was bathed each evening. As a rule, residents said they enjoyed their bath and looked forward to it. If a resident was bathed in the Century tub, he required a staff member to be present to operate the lift and water flow. Two residents said this was the reason they did not have a Century tub bath, but most of the residents said they did not mind this assistance. Residents who were independent often used the tub and shower for bathing.

Staff assignments were made so each aide was responsible for only one or two resident baths a day. If the assignment did not seem fair in this regard, there was a voluntary redistribution of the work load so all staff shared equally in this aspect of care. The timing of the scheduled baths was organized by the aides each morning. Some residents had an informal arrangement with the staff to be the first man bathed. If a resident had an appointment or outing planned, the staff would complete his bath early. Although one resident stated he enjoyed having the last bath of the day as it allowed him to soak longer, for some men, the earlier the bath, the better. Some

residents were given an estimate as to when to expect their bath, but often, the men just waited for their turn. The Century tub took several minutes to fill, and as one bath was completed, the tub was cleaned and refilled for the next staff member to use.

If able, the resident would prepare the clothes he would wear for the day. Otherwise, the staff would gather up a change of clothes based either on the resident's preference or their own judgments. The door to the tub room was usually closed during the bath, and the curtains that separated the two Century tubs from the rest of the room were drawn. The curtains between the two tubs were less often closed. The men undressed independently or were assisted by the staff and sat in the lift chair which raised and lowered them into the tub. A towel was sometimes placed over their lap as they were moved into the bath. The men did not seem reluctant to be assisted by the aides in this procedure. As there were two Century tubs, two residents were bathed at the same time, and at least two aides were in the area during the procedure. Residents were encouraged to wash themselves. Conversation during the bath sometimes included the resident, but at other times, it was between the two aides and the resident was excluded. The two residents being bathed seldom communicated with each other.

For each team on the unit, there was a "bowel book" where the resident's bowel movements were recorded. Each aide was responsible for making sure that this information was recorded for their assigned residents. As a rule, staff became concerned when a resident went three days without a movement although staff also were aware of individual idiosyncrasies in this regard. Some residents only required prune juice, while others required more aggressive interventions. For many of the men, attention to bowel functioning was an important aspect of their health. Individual servings of a special mixture that contained natural laxative ingredients such as bran and prunes were set out each morning at the desk . Men would stop at the desk on their

way to or from breakfast to pick up a serving if they felt the need for it. Each day there was some discussion regarding a resident's bowel activity in the regular staff reports.

The registered nurses would distribute medications to the residents in the morning as the residents made their way to and from the dining room. Many of the residents would come out to the desk to receive their insulin and collect their pills. These men would stop at the desk and wait for the registered nurse to notice them and bring them their pills. Occasionally, they would call out to remind the nurse that they were there. At other times, the nurse would notice the resident moving by the desk and ask them to wait for their pills. Those men who did not come to the desk would have their pills delivered to them from the large medication cart. Residents, if able, would come out to the desk to request analgesics or other medications. The registered nurse would usually administer these medications at the desk area as the resident waited. During the night shift, residents would ring their bells for assistance.

Approximately one third of the residents had occupational or physiotherapy programmes regularly scheduled during the morning or the afternoon. The appointment times were listed on a schedule on the unit as well as on the bulletin board outside the department's door. It was the responsibility of mentally competent residents to be on time for their appointments. Other residents just needed to be reminded either by the ward staff or the department staff. For group activities, the ward clerk would call the residents' names over the intercom system. Although most staff tried to be cognizant of residents' appointments, sometimes care activities on the ward (e.g., bath day) would interfere with the physiotherapy sessions. When such a conflict occurred, the onus tended to be on the resident to inform the staff that they needed to delay their ward care until after the therapy. Often, the residents would not remind the staff that they had an appointment, and they would miss their scheduled physiotherapy.

One of the objectives for the men receiving physiotherapy was to maximize their mobility. The physiotherapy staff would walk men capable of ambulating until they were able to manage a distance of two hundred feet. At this point, it was the responsibility of the unit staff to walk the resident. Unless the residents were specifically motivated, few of them would ask to be walked, and gradually, without a regular walking programme, they would lose the ability to walk safely. These men would once more need to be seen by the physiotherapist to restore their previous level of ambulation.

Men could drop into the physiotherapy department to use the equipment as long as a staff member was in the room. Men did use the weights or the bicycle on their own. For many of the residents, physiotherapy was viewed positively because it improved their status and provided more independence. When therapy was not ordered or therapy sessions were decreased, the men interpreted this as a loss of hope for improvement. Occasionally it was necessary for the staff to assist residents who had unrealistic expectations, to accept their prognosis and the staff would gradually decrease the appointment times each week. Two residents did comment that they felt staff should never destroy their hope as it was all they had in the facility. In other situations, the resident, himself, lacked the motivation to attend the programme. Some residents, especially the cognitively impaired, would view the treatment as cruel and painful and were unable to understand the reason for the therapy. In these situations, the staff reconsidered the utility of the programme. Ultimately, the resident had the choice not to attend therapy but not always the opportunity to attend.

Both group and individual sessions were organized for residents receiving occupational therapy. One computer had been set up with programmes for specific residents. One resident had been assigned to record daily the weather forecast from the newspaper. Although he initially seemed enthusiastic with the task, he had gradually

stopped doing it. There appeared to be no follow-up when he did not attend. Computer games and writing programmes were also used by the residents. There was a weekly cooking group where the men were responsible for planning the menu, buying the supplies, preparing the food, and cleaning up afterwards. The residents especially enjoyed cooking a meal as it provided a change from the regular dining room food. This department also arranged reality therapy and current events groups for specific residents. The exercise programmes were mainly for increasing flexibility rather than improving strength.

With the exception of the cooking programme, few of the occupational therapy or physiotherapy sessions lasted longer than an hour so most of the day was unstructured. Each competent resident had his own specific routine during the day. Most spent some time in their rooms watching television or just laying on the bed. The time spent in their rooms varied from resident to resident, with some staying in their room all day except for meals and others returning only for a short nap after lunch. The coffee shop, arts and craft room, and the sunroom were frequently visited either for a cigarette or a coffee. Nonsmokers tended to stop in the front corridor. Some of the ambulatory residents would walk outside if the weather was good. Residents who were able went out on their own, often by taxi. One man regularly went out to the Legion hall for two beers. He would leave about 11 in the morning and return shortly after lunch. He told the researcher that he felt closer to the men at the Legion hall. When he did not show up at the Legion hall for several days, they would ask about him.

Lunch was served at 1145, 1215, and 1230. Men would start making their way to the dining room by 1115. After lunch, many of the men would return to their beds to rest for an hour or more. Most of the mentally incompetent men were put to bed for a sleep. Afternoon recreational activities would start after 1400 hours and last from one

and a half to two hours. As well as the organized recreational activities, physiotherapy and occupational therapy programmes would be scheduled for some residents.

Dinner was served between 1645 hours to 1800 hours. The staff started to put residents to bed as soon as everyone had finished their dinner, about 1830 hours. Usually, the men who were mentally incompetent were put to bed first. These men had their face, hands, and perineal area washed. Men who were incontinent were padded and some slept with the urinal in place. The majority of the men used the pyjamas provided by the facility. Most of the men went to bed between 2030 hours and 2230 hours although many would lie in bed and watch television for awhile longer. A few men would still be up when the night staff came on duty at 2300 hours, but most of them were asleep by the time the first rounds were made at midnight.

During the night, the staff made rounds to each room every two hours. Men who were incontinent were checked and their linen changed with as little disturbance as possible. Urinals were quietly checked and emptied. Residents who called usually needed a blanket, analgesic, or drink. The aides were able to anticipate many of the bells and knew what the request would be without asking. Two or three of the men would wander during the night, and the staff were particularly vigilant of them. By 0400 hours, the occasional resident was already awake. By 0500 hours, there was resident activity in the corridor and by 0630 hours, the constant flow of men to and from the coffee shop and sunroom started for the day. The day staff began arriving at 0645, with report at 0700 hours.

Special Events

Events were organized for the residents through the recreational department. There was a full-time director and three other staff involved in these activities. Volunteers assisted with many of the functions. These were organized on a weekly, monthly, and yearly schedule. Events were also organized for special occasions. The recreational department would prepare a calendar each month with the events listed that were planned for the residents.

Twice a week, members of volunteer organizations would come in and hold a bingo for the residents. These groups would assist residents who had difficulty with the process as well as call out the numbers, check winning cards, and distribute prize money, which usually ranged from $2.00 to $5.00. Each night, 20-25 men participated in this activity.

Twice a week, there was a social night or happy hour that was sponsored by the various Legions in the city. Men were allowed two beers at this event. Generally, music or other entertainment which often included a sing-a-long, was provided. The men sat at tables for four residents, and spontaneous interactions between the men were more common at this event than in the normal course of the day.

Birthdays were acknowledged on the specific day by a cake and a card from the dietary department. There was a general birthday party each month for residents in the facility who had a birthday that month. Residents from both units attended. The party was held in the arts and craft room, and over half the men would attend. Usually, a band would provide entertainment. Lemonade and cookies would be set out on the tables. A birthday cake decorated with sparklers would conclude the afternoon event. Not all the men who had birthdays would attend. One resident who did not attend told the researcher that he did not see why getting older should be celebrated. He added that he had gone out for dinner with his family on the actual day and that was what was

important. Residents needed to show the initiative to get down to the event as staff did not always assist the resident to be ready for it or remind them to go.

Also there were activities which had less general appeal. Once a week, a chaplain led a bible study for the men. Six to eight men attended, and in this case, the chaplain would seek out men who usually enjoyed the event and were absent. Recently, a literary club was started for discussion of books.

There were weekly shopping excursions to the various plazas in the city. These were listed in the monthly calendar of events and posted on the notice board on the day of the outing. Men who wanted to go out would tell the staff, and the recreational department would try to accommodate them. Volunteers to assist the group as well as transportation would have to be arranged. The shoppers would leave at 1000 hours and remain out until after lunch. For many of the men, eating lunch out was the main attraction of the shopping trip. Sometimes the staff would identify articles that the resident required and would either accompany the resident or else tell the volunteer who went with the man what was required. Each resident had a volunteer or a staff member accompany him, and often, the shoppers would remain in a group for the expedition. One resident expressed resentment at this supervision and avoided such shopping trips.

Another outing was swimming. This also involved one to one supervision by either staff or volunteers. In this situation the attendant would assist the men with changing at the pool as well as accompany them into the pool. Two or three residents regularly participated in this activity.

Opportunities were also available for residents to attend concerts and sports events. A limited number of tickets were purchased by the recreational department for distribution to the residents. Some residents would purchase their own tickets for events that were of a particular interest to them. Again, each resident required an escort, and in this situation, volunteers were required to purchase their own tickets.

The recreational department in cooperation with the staff tried to ensure that the tickets were fairly distributed among the men.

The unit staff also organized and assisted with diversional activities that included both outings and in-house activities. Outings included trips to various parks as well as trips to restaurants and other local points of interest. Five to 20 men participated in these events depending on the type of outing and the number of staff available to accompany the residents. One such outing was to an orchid display at a local conservatory. Five men were able to participate in this excursion accompanied by two unit staff, two recreational staff, and one volunteer. Although three of the five men could walk, wheelchairs were taken for all men to avoid fatigue. The day of this outing was cold and all men needed to be warmly dressed. In order to make sure the men were warm, the staff utilized a common bag of gloves and hats and borrowed warm coats from other residents for those going out. One resident still chided the staff when he arrived at the conservatory for not putting on his long underwear for such a cold day. All aspects of the outing appeared to be savored by the men, from the transportation along the busy streets to the conservatory, the brisk afternoon air, the sounds, smells, and sights of the conservatory, to the hot coffee at the tea shop. Once back at the facility, the staff enthusiastically shared with each other the positive response of the men to the trip.

The staff also participated in ward events. A pancake breakfast was held on the ward for Shrove Tuesday. All men were able to have breakfast of sausages and pancakes cooked and served by the staff on the unit. Other such events which were supervised by the unit staff included ice cream parties and barbecued dinners in the courtyard area.

When a resident died in the facility, the flag would be lowered to half mast as a show of respect for the deceased. Residents would notice the flag and make inquires

about the identity of the person. Other than this, the residents spoke little of the event. Rarely did they attend any of the funeral activities associated with the death. One man did speak of a resident who he had considered a friend. Although he had felt a desire to attend the funeral, he had not as he was afraid he would break down during the service. Each year in late November, the facility had a memorial service for all residents and staff who had died the previous year. Residents, staff, family, and friends were invited to this event. Many of the competent men attended the service and approximately 60 family members and friends. After the ceremony, there was a reception. Although few of the unit staff attended the service, many went to the reception later to speak with family members of late residents. Several residents who were not present at the service did attend the reception.

V. FINDINGS: INTERACTIONS ON THE UNIT

The most striking feature of the unit was the conspicuous lack of conversation between the residents. Although competent residents sat together within comfortable conversational distance, they usually sat in silence. Many of the men appeared to ignore others on the unit, passing each other in the corridor without verbal or nonverbal greeting. Only two or three of the residents did not consistently conform to this pattern, and everyday they circulated around all the residents conversing and exchanging small talk. The response of the residents who were less communicative to those who made the effort to chat with them was varied. Some responded with enthusiasm, some with more reticence, while others acknowledged the greeting with a wave or a nod. The overall "tone" of the unit was cordial, with a reserved cooperation between residents.

The void in masculine chatter was filled by the sound of staff conversations between each other or with the residents. Background noises were constant and continuous, consisting of the hum of the air conditioner, static calls of the intercom, jangling of phones and call bells, and the rattling of trolleys and carts. Although these persistent background noises undoubtedly interfered with the elderly residents' ability to hear and inhibited conversation, the lack of effort to communicate with others remained a predominate feature.

The floor plan of the unit required the residents to be in close proximity to each other most of the day, and there were few nooks or comfortable corners in which to withdraw from the constant view of others. All of the residents, with the exception of five men, shared a room with at least one other person. Meals were taken in three seatings in a common dining room which was shared with approximately 74 additional residents from an adjoining unit. Residents sat at tables of four, and even in this

setting, there was little conversation. If residents wanted to smoke indoors, they were required to do this in designated communal areas. Organized recreational activities also involved sharing the event with others. Travel from one place to another within the facility inevitably resulted in the resident encountering another resident along the way. Thus, even though there was substantial opportunity for the men to interact, many of them did not show interest in the activities of the ward, or with the other residents if it did not directly concern them.

Analysis of the residents' interrelationships revealed three kinds of interactions. The first type of interaction was *personalized,* or how people would normally be expected to be treated. There was recognition of the person as a unique individual with specific qualities or characteristics. With the second type of interaction, labelled *stranger or depersonalized*, no attempt was made to acknowledge the uniqueness of the person, interaction was rote, infrequent, and lacked warmth. With the third type of interaction, the person was *dehumanized*, spoken to impersonally, and spoken *at* rather than *to* , that is, treated as though the person was not present. In the first type of interaction, there was an acknowledgement of the individuality of each person and a recognition of his/her right to self-determination. This characteristic was less apparent in the *stranger* mode of communication, and it appeared to be absent in the *dehumanized* mode of communication. Four routes of interaction directly or indirectly involved the residents . These were resident-to-resident, resident-to-staff, staff-to-resident, and staff-to-staff. The descriptions of each of the three communication patterns (i.e., personalized, stranger, dehumanized) will be given for each route. The relationship of privacy maintenance to each communication pattern will be discussed at the conclusion of all the descriptions.

Personalized Patterns of Interaction

Resident-to-resident.

Despite the lack of communication, some residents demonstrated a genuine interest in other residents and recognized the individuality of others. In particular, two residents were well-known on the ward and knew all the men in the facility by name, including those who were residents on the adjoining unit. These residents would be aware of the days' activities on the unit, the daily activities of individual residents, and could recount anecdotes about them. For example, following a hockey game on television, they would seek out supporters of the losing team and engage in good natured teasing or seek supporters of the winning team and rehash the victory. They would address men in the corridor with friendly acknowledgements and greet men who were less competent with an enthusiastic "Hello there old timer!" or a "Hello there young fella!" The recipient of such an acknowledgement would immediately brighten and respond with words or a wave. These more out-going residents would deliberately sit near other residents in the communal areas, and although visiting back and forth between resident's rooms was uncommon for most of the men, they would occasionally drop in to visit with those residents who seldom left their rooms. In these ways, some residents, in a personalized pattern of interaction, actively initiated conversation with others.

Similarly, although few residents were observed assisting each other directly, some men did anticipate the needs of other residents and offered assistance when it was necessary. For example, if these men noticed that someone needed a light for a cigarette, they would offer one without being asked. They would offer a cigarette or purchase coffee for residents who were considered mentally incompetent and were unable to go to the coffee shop, commenting that it was "the least they could do for them." These residents would regularly volunteer to push men in wheelchairs to and

from the dining room. One resident who was a frequent recipient of this assistance appreciated that it was offered and not just given. He said, "There is one resident who, when he sees me going to the dining room or anywhere, he says, 'going down or coming home?' He treats me like a person who has a choice to receive his help." This approach was in contrast to another incident where a resident came up behind a man slowly making his way in his wheelchair and assisted without any comment. The resident was quite startled and vocally reprimanded the resident for the assistance. Another offer of assistance regularly occurred in the dining room and it involved one resident who would deliver and tie on the bibs for four or five residents. The opportunity to accept or refuse the assistance was apparently as appreciated as the assistance itself.

Roommates acted as advocates and mediators for each other. They were observant of the physical condition of their roommates and acted to ensure adequate care was given. Sometimes this assistance was merely ringing the bell to call a staff member, but on other occasions, it required the resident to actively seek out help. Residents were protective of others who were unable to assert themselves and they would make sure these residents were given appropriate care. Behaviors which demonstrated an interest in the welfare of another occurred in the regular fitness classes. Here, men would attempt to include all members by deliberately hitting the ball toward those who were less involved in the activity. One man even called out to others to keep working and exclaimed "ata boy" to those who responded to his encouragement.

Courtesies were extended to both competent and mentally incompetent residents. Competent residents seldom interrupted conversations between the researcher and an informant. Occasionally, a resident would ask if he could sit nearby. Once while the researcher was talking with a resident, a mentally incompetent resident

joined them at the table. The informant would politely acknowledge the comments of the mentally incompetent man each time he spoke even though the content would be irrelevant to the conversation.

Thus, in the *personalized* relationship, residents demonstrated caring behaviours to other residents by anticipating needs and offering assistance. Residents would allow each other the opportunity to accept or refuse such help, thus acknowledging their freedom to make independent decisions. There were normal demonstrations of friendship as residents sought out each other for company.

Resident-to-staff.

In personalized interactions with the staff, residents appreciated that the staff were more than individuals responsible for their care. There was an acknowledgement that the staff had a life outside the work place, and these residents were interested in the staff as individuals. Although the residents may have been dependent on the staff for specific assistance, they appreciated that the staff member came from a broader social context.

Although residents were not always able to identify particular staff by name, it was obvious from the expression on their faces when care was given by a staff member with whom they felt comfortable. Spontaneous smiles and warm greetings were evidence of this recognition, and this, in turn, was appreciated by the staff. Such acknowledgements were facilitated when residents knew their assigned caregiver for the day and were able to distinguish individual caregivers. Although in one situation, staff recognition was a source of amusement because the resident consistently confused two staff members who were of similar build. This seemed to create a common ground on which these staff members and the resident could interact.

A common interest would often provide the grounds for a special relationship between a staff and a resident. Residents could identify staff who shared an interest in

a hobby, a language, a sports event, or a horticultural endeavor. Such points of interest would be the basis for regular conversations, and it also allowed the resident an opportunity to relate to the staff member outside of care activities. One resident looked forward to having an aide who was able to communicate with him in Italian. Although it was not his first language, he enjoyed the experience of using a skill he once knew well. He commented to the researcher that she was special to him and treated him like a friend.

Men would show an interest in the staffs members' welfare by asking about winter road conditions, an illness that the staff member had been suffering from, or special events in their lives. Such interest showed that the residents had a view of the staff beyond the facility and the role of a caregiver.

The residents were sensitive to the possible problems associated with caring for others:

> Here you can ask them [the staff] to do anything for you within reason, and they'll do it. I've seen some of these guys yell and bellyache. They are only people trying to do a job, too, and some of these guys expect too darn much. We have a wonderful staff here.

These residents would recognize that at times routines could not be followed. Whenever there were unexpected delays, they would be philosophical about it, and they recognized that there were no real time constraints. One man spoke about his bath and said, "It would be nice to get done early, but what the heck do I need to rush for?"

Residents would demonstrate their appreciation of special attention by giving selected staff gifts and treats, such as, chocolate bars, candy, pop, and coffee. Although such rewards were done at times to manipulate future interactions, other gifts represented genuine appreciation for the care received from specific staff members. Family members acknowledged staff efforts by bringing in treats such as homemade

cooking, potted plants, or candies for the staff. Residents and their families also brought the staff souvenirs when they returned from holidays. Most of these concrete rewards were given as an expression of appreciation to the staff for the care given to the residents.

In the personalized interaction, the resident was able to approach the staff member as an individual, there was an interest in the staff member beyond the caregiving role. Residents would express an interest in the staff member's health and safety. Residents would demonstrate an appreciation of a particular staff member's uniqueness. This may have been simply knowing the staff's name. In other situations, a common interest provided a bond for interaction beyond the caregiver role. The residents also appreciated those activities that were care-related, and selected staff were rewarded by gifts or compliments.

Staff-to-resident.

Although the responsibility of the staff to the resident was basically in caregiving activity, in a personalized interaction, staff did acknowledge the resident beyond this caregiving role. The staff realized the resident had a past, present and future. On the corridor walls, there were photographs reflecting the military experiences of the residents. These pictures revealed men young, healthy, and independent. As well, many men had additional pictures in their rooms of family and events that were meaningful to them. These photographs would give staff members something to discuss with the resident; consequently, they were able to share an aspect of the man's life beyond the facility. Sharing was important, and staff would reciprocate by bringing in personal pictures of family and events to show to the residents.

Staff also attempted to share in the present life of the resident in a broader context than by merely providing physical care. Arrangements were planned to

celebrate special events in a resident's life, such as, birthdays, anniversaries, and other milestones.. Clothing was prepared so the resident would be properly dressed for such occasions. Often, a staff member was required to go out shopping for the resident. If the special event was reported in the newspaper, such clippings would be displayed on the unit and enthusiastically shared with ward visitors.

Staff were instrumental in initiating projects that allowed for diversional activities for the residents. They recognized that many of the residents required more opportunity for social interaction and integration. To facilitate this social interaction, staff organized both on-ward activities and outings to local attractions and places. Fund raising projects for minor expenses associated with some of the activities were organized by the staff. Such activity allowed staff to share pleasurable occasions with residents and see the resident in a context outside of the unit situation. Although such events and outings would require extra time and effort from all staff, they saw it as a valuable way to improve the quality of life for the residents. Staff would enthusiastically share how the men had reacted, and for days after they would discuss the occasion with residents, who otherwise were generally less communicative.

Staff also attempted to maintain continuity with the resident outside of the facility. When residents were admitted to the hospital, it was customary for the staff to regularly inquire about the man's condition. Staff would visit him in the hospital, bringing a card signed by those on duty. Residents appreciated these visits, mentioning them to the researcher when they returned to the facility.

Residents depended on the staff for encouragement and approval. One man said, "I want to be sent home with everyone's consent and [everyone] wave goodbye to me and wish me luck." There was also a need for staff to support hope in the resident. This could be by direct verbal encouragement in recognizing even small achievements or indirectly by assisting with rehabilitation activities that allowed the resident to

maintain the maximal level of functioning. In this way, staff were demonstrating an interest in the future of the resident. Staff members also encouraged residents by recognizing their potential in often neglected areas. Despite one resident's severe hearing and sight impairment, a staff member spent time with him teaching him a short poem. Reciting the newly memorized poem gave this resident a sense of accomplishment which he seldom experienced.

Staff interaction usually occurred whenever some assistance or care was required by the resident; therefore, the amount of time staff spent with individual residents often depended on what care was required by the resident. It also provided the resident with a situation where he could anticipate staff interaction. There were casual greetings in the corridor initiated by either staff or residents but sustained conversations were not common. Friendly communication occurred more regularly in informal settings such as outings and recreational events. Some staff members, in less busy times, would sit with residents either just to talk or to play a game of cards with them.

Interactions between staff and the resident that were spontaneous and not task driven were appreciated by the men. Often, at the beginning of a shift when staff met a resident in the corridor, they would show genuine pleasure in seeing him. Cordial greetings by the staff often accompanied by a physical touch to the shoulder and the use of the resident's name, would be enthusiastically received with a smile, a nod, or words of greetings by the resident.

Other common courtesies were extended to the resident. Some staff would start each shift by making rounds and telling their assigned resident that they were their care aid for the day. At this time, any activities that involved the resident would be discussed. In this way, confusion or misinformation about appointments could be clarified. New staff and visitors were introduced to residents who might have contact

with them. Delays in care were explained to residents, or changes in routines were discussed with those involved. Dealing with discrepancies immediately, even when minor in nature showed that the staff felt the resident was more than a recipient of care but an active participant in the whole care process.

Staff volunteered to do special favours for these residents. They would volunteer to do shopping for the men or pick up articles when they were doing their own shopping. Staff would assist residents to adjust to the facility by suggesting ways to personalize their rooms. This sometimes involved taking the resident around to view other resident rooms in the facility in order to give the resident ideas of what was possible. Another resident said he appreciated a staff member who did not view him as just a resident and was willing to bend the rules a little for him:

> You know I needed a doctor to order my nightly brandy. It took a while for her to write it down. Some of the nurses wouldn't give it to me until it was written, but____ would say, "ah____you've had this all the time so it won't hurt you now." Some of the nurses when they pour it hold it up to their eye and measure it to the last drop, but_____ just gives me my shot of brandy to sleep.

He felt this nurse appreciated him as more than just a resident in the facility but as a person.

Although the staff were primarily involved with the resident during care activities, some staff did interact with the resident in a way that acknowledged an appreciation of their uniqueness. When the resident was aware of the name of their specific caregiver for the shift, this relationship could be reciprocated. There was sharing of significant events either directly when staff participated with residents in celebrations or indirectly when these occasions were shared only in picture and story form. Recreational outings provided opportunities for staff and residents to interact in informal settings and thus appreciate each other beyond the caregiver role.

Staff-to-staff.

Analysis of how staff referred to residents when speaking with each other about the residents was one way to discern how staff perceived the resident. Communication between staff members concerning residents occurred both formally and informally during the day. Formal communication occurred during change of shift. At this time, the staff coming on duty would listen to the taped report from the previous two shifts. Team conferences were held each afternoon when residents were reviewed. Specific care needs of individual residents were identified at this time, and suggestions for changes discussed. During team conferences, discussions tended to be less formal, and more anecdotal information was shared. There was also informal communication about residents that occurred spontaneous either during breaks or whenever two or more staff were together. At this time, staff would discuss their frustrations with specific men as well as recount humorous or anecdotal stories. The staff also reminisced about former residents, sometimes drawing comparisons with men now on the unit.

The personhood of the resident was acknowledged when staff-to-staff communication was aimed at providing a more personalized plan of care that accommodated the needs of the resident and the restrictions of institutional life. These interactions would respect the confidences of the resident, include the resident in decision-making and attempt to support the uniqueness of the resident. Objective reporting of factual information that affected the care plan was communicated between shifts. Information, such as, the development of reddened areas, the need to alter a medication, or a change in condition requiring staff to adjust the resident's normal routine, were most frequently reported. Staff who recognized the resident as an individual reported difficult or unusual behavior in the context of the situation. There was an attempt to understand the occurrence and offer an explanation of the behavior.

One resident was particularly uncooperative and unpleasant one evening, refusing his dinner and all care. These behaviours were reported but the staff member also added that the resident had been out with his family for the afternoon, that he was unhappy at returning to the facility, and that he was quite tired from the excursion itself.

Staff often communicated informally with each other in order to share precise directions related to specific routines for individual residents. Staff who attempted to accommodate a resident's often fastidious routines acknowledged an appreciation of the resident's unique personality traits as well as his physical needs. Changes in the plan of care most often were initiated by the staff. Although the initial problem would be identified by staff, no changes were made until the resident had been consulted.

Informal communication frequently involved the recounting of stories concerning the residents. Although the anecdotes were often humorous, the stories were recalled with warmth and tenderness. These stories revealed an appreciation of the humanness of the resident and occasionally the errors in the staff member's own thinking. One resident, who was cognitively impaired, complained to a staff member that he was unable to find his room since the ducks had left. Initially, the aid just assumed the resident was a little more confused until the staff member remembered that the lawn ornaments had been recently put away and the ones outside this resident's room had been ducks. This story was told to the researcher with a genuine affection for the resident.

For the resident to be treated as a person, confidences must be respected. Personnel who were involved in letter writing or banking for the residents said it was important not to communicate the information they received to anyone. For those residents who required someone from the facility to do their banking for them, the bankbook would be delivered in an envelope to the cashier along with the instructions. The cashier would carry out the instructions, and the bankbook would be returned to

the resident in the envelope. In this way, the resident retained control over the information concerning his finances.

For the resident to be acknowledged as a unique individual, communication between staff concerning the resident should ultimately deal with the resident's personalized care plan. Individualized care that accommodated specific requests of the resident as well as the general needs of the unit were the result of joint planning by both staff and resident. The sharing of confidences of residents would only be done with the agreement of the resident and ultimately to improve the quality of life of the resident.

Stranger Patterns of Communication

Resident-to-resident.

In the stranger or depersonalized type of interaction the men seemed to ignore the other men on the unit. In the dining room and other communal areas in the facility, there was minimal interaction. Men would enter and leave the smoking lounge and avoid establishing eye contact with those in the room. They seemed to treat each other as strangers with whom they shared nothing in common. They passed other residents in the corridor as strangers pass on a busy street, eyes held straight ahead with no acknowledgement of the presence of others. Greetings in the dining room, if made, would be trite. One man explained that two of the men greeted each other every meal with the same expression: "I see you made it." To which the other man replied, "Yes, and I see you did, too." Other than that exchange, no words would be spoken during the meal.

Residents often displayed little interest in the others who shared the building. Only four residents actually knew the names of the men on the unit. Other residents would be able to identify their roommates, but when asked who they shared their room

with, several men said "Oh, I know them to see them." The same response was given when asked who they sat with in the dining room. Several residents knew only two or three men on the unit by name. Often, they knew their roommate; although occasionally, those they knew shared a common heritage or armed forces' history (e.g., same battalion). Name recognition, although often considered an important indicator of familiarity, was not always an accurate representation of this for the residents. As discussed earlier, some of the men were unable to name other residents; however, there were behavioral responses when they met others which indicated a recognition.

In the coffee shop, some of the residents would discuss a variety of ward activities; however, many of the residents did not participate in these discussions. Residents were often unaware of changes in the condition of other residents. Although friendly when addressed, these men would show little interest when told of significant developments in other residents' lives. Absence of a resident from the ward would go unnoticed. One resident was transferred to the hospital with cardiac arrthymias one Friday evening. When the researcher inquired about him Monday morning, several of the residents were surprised that he was not in the facility. Although this man spent much of his time outside his room, his absence went unnoticed by several of the men who would have normally been in contact with him.

The prevalent characteristic of resident-to-resident interaction when it was depersonalized was the resident's lack of involvement with each other. Communication was often superficial comments with no real attempt to acknowledge any familiarity. Although there were no negative feelings, there were also no substantial feelings of warmth between residents.

Resident-to-staff.

Incidences of resident-staff interaction were predominantly associated with care activities. The resident would approach the staff most often with a request or question concerning their care. It was uncommon for a resident to address a staff merely to socialize beyond the brief exchange of pleasantries. Many residents did not attempt to learn the names of the staff or to distinguish one from another. The majority of the staff had been employed on the ward for over two years and several for five years or more. The following exchange was typical of conversations between the researcher and residents:

I. What about the staff—do you know the staff very well?

R. Well, it is pretty hard to know them cause they come and go all the time.

I. Do you know any of them by name?

R. Well I know ___, she works Sunday afternoon. She has been here since I came. And there is ___. She's on the other end. The rest, they are changing all the time. I don't know why either.

I. Do you know the ward clerk or the head nurse?

R. No, she's gone.

I. What about the assistant?

R. No, not very much.

If little attempt was made to distinguish between staff members, when some aspect of care was unsatisfactory, all the staff would suffer the brunt of the resident displeasure. Little effort was made to identify the staff person responsible. Similarly, if a resident was required to wait, he would be quite unreasonable even if there was a good reason for the delay. No attempts to placate the resident would alleviate his annoyance.

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In depersonalized interactions residents acknowledged staff only in their role as a caregiver. Those staff members who were able to assist a resident according to his

expectations were positively evaluated. One resident when speaking of his weekly tub bath said, "sometimes the *good staff* will slip me in early, but not too often." Similarly, staff members were rewarded or punished by residents based on the satisfaction the resident felt with his care. Occasionally, residents would compliment staff members by name, but more often, satisfaction with care had to be inferred from expressions like "that went well" or "you did that easily." One staff member felt complimented when a resident told her she was one of the few staff members who could give him a suppository "so it would work."

Staff members identified residents who would punish staff when they were unhappy with their care. One resident would refuse to speak to staff even to say "good-morning." Other times, residents would refuse to cooperate with care or delay care, or they would become very demanding. Staff also identified incontinence as a way some men would try to punish them. Such forms of punishment did not acknowledge the staff as competent adults but as children that needed to be disciplined to behave correctly.

Staff felt the men saw them only as their employees and therefore in a subservient position to the resident. This employee-employer relationship would be emphasized when a resident threatened to report a staff member for not carrying out his wishes. Conflicts often developed over the extent residents were expected to be independent with care. One such disagreement ended with the resident threatening to go to the nursing director, whom he identified by name, if the staff did not comply with his expectations. Similarly, staff were reported to the administration when the resident felt some aspect of care was unsatisfactory. Such action, when it was done without attempting to resolve the situation at the ward level, failed to acknowledge the right of the persons directly involved to attempt to improve the situation.

Residents who interacted with staff members in a depersonalized manner saw them only in their role of caregiver. This type of interaction reflected an employee-employer relationship, and there were few concessions made to accommodate the circumstances of institutional life.

Staff-to-resident.

When there was a loss of appreciation of the resident as an individual with a distinctive personality, the interaction of the staff and the resident became more role oriented. In this situation, the relationship was cordial but distant often considered professional. Frequently, decisions were made for the resident, and he was denied the autonomy normally afforded a competent adult. Thus, the resident felt he was treated as someone less than a man. One resident said that the staff "too often are doing a service to a *thing*—to a person of no account." Another man recognizing his changed status explained, "You see, I've reverted back to an infant, if you get what I mean. Maybe it don't squawk —I guess I squawk more than a baby does." Such statements demonstrated the loss of personhood felt by some of the residents.

Residents were known to all staff by name. Forms of address varied depending on the preference of the resident. Some men preferred to be called by their first name, while others were addressed as "Mister." Diminutive terms such as "dear," "lovie," "sweetie," and "gramps" were not used by the staff on the unit. Residents, however, were labelled as demanding if they refused to accept decisions made for them by others or if they were particularly specific as to how care activities were carried out. Residents were also seen as manipulative or dependent if they attempted to get assistance beyond that which the staff felt was necessary. One resident recognized that encouraging the resident to be independent as possible was important, but he felt it was not always dealt with appropriately:

> They refuse to believe I need help, and a nurse will come and answer the button and will say "and what do you want," and I will say—and they will say "Oh you can do that. I saw you do it this morning." They refuse to believe me, and then the next nurse will come along, and she'll help you. And I think there should be some limits as to how much each individual can perform or not perform.

This inconsistency of resident assessment may have reflected staff attitudes toward a particular resident rather than an objective assessment of the man's abilities.

By ignoring resident complaints and observations, staff challenged the ability of residents to make decisions of a competent adult. One resident gave the following account of such an incident:

> Well I don't know if this has anything to do with health or no, but the toilet plugged up. I went and told them, "I need a plumber." Well, they looked at me like the bunch they've got tied down—you know, they have men tied down? One of the nurses came down and flushed the toilet and water went all over the place. It wasn't good enough, my word wasn't good enough to tell them. And I said to the nurse, the same nurse I had reported it to: "Why— is not my word good? You run down and flush the toilet." I don't see good, but I can see when a toilet's flushed. If I'm good enough to go and tell them about it, they should be good enough to listen.

Similarly, residents felt ignored when there was no response to their requests or they were not given results to diagnostic tests. Sometimes, although given the information, residents required further explanation, but instead of this being provided, the resident felt they were avoided. One man, although given his test results to read, was not able to understand the implications of the report and waited several weeks until the specialist's appointment to know that he would be a candidate for corrective surgery.

Broken promises and time schedules that were not followed also irritated the men:

> So they give you a promise, and you know the most used word in here by the staff is "just a minute," "wait a minute," "I'll be right with you." They forget to come back, and that minute turns into hours. It's a heavily used word.

The use of such expressions to simply put off any further discussion of the delay seemed to deny the resident the right to an adequate explanation. Most residents expected adherence to established routines and were upset if there was a deviation from the normal pattern of events. Sometimes routines were adhered to when it was to the detriment of the resident. For instance, one man was excessively short of breath one morning. He was to have his weekly tub bath later in the morning and had just returned to bed to rest prior to this activity. A staff member insisted he get up again as she was making beds and wanted to "get this room done." When such a conflict between staff and resident occurred, the ultimate winner depended on the assertiveness of the resident. Some residents would be adamant in their demands and successful in their requests; whereas, others who were less assertive would defer to the wishes of the staff.

Staff treated residents like a stranger whenever the acknowledgement of the person involved only an individual requiring care in the institution. As a result of this dependent relationship, residents would be treated as less than a man or as a child. Interactions would be rote and often directive instead of revealing any desire to encourage the resident to share information that was meaningful to him.

Staff-to-staff.

The personhood of the resident was diminished when the resident plan of care became activity centered and the needs of the facility assuming a more predominate position than the needs of the resident. Formal reporting focused on the care activities

that had occurred during the previous shift. Behaviors were reported that had influenced the normal unit activities, but there was little attempt to understand the situational context of the behaviors.

During team conferences, staff reported on care activities that had been completed and discussed difficulties that had been encountered. At this time, suggestions were offered that might improve the plan of care. Frequently, there was an acknowledgement of the need to involve the resident in planning, but the resident's involvement was at the point of changing the actions and not at the point of establishing the goals for care. During one report, it was decided that one resident should have his bath day changed as it was scheduled on the same day as his physiotherapy session and bowel day. He was given the choice of two other days, but he was not asked if he desired the actual change.

Staff often made the decision as to what information should be shared with other staff members. This included information that the resident had discussed with staff on a personal level. Although residents seldom identified information as confidential, a clearer identification that such discussions would be used for planning care would have given the resident more control over information.

When staff only saw the resident from a caregiver perspective, fewer stories were related. These stories were care-focused, and there was no feeling of warmth for the resident communicated.

Staff-to-staff communication at the depersonalized level did little to develop a plan of care that reflected the specific concerns of the resident. Specific physical needs would be acknowledged, but individual resident input would be limited.

Dehumanized Patterns of Communication

Resident-to-resident.

As one man was being pushed to the dining room, he referred to those residents who were slowly making their way along the corridors on their own as "the unavoidable and unfortunate obstacles that need to be dealt with." This comment demonstrated the tendency of some residents to react to others, especially the mentally incompetent men, with no consideration of their humanness. They were treated as objects or life forms with no redeeming qualities. These residents would react angrily when they were impeded by men who were slow or mentally incompetent. One man would intentionally run into anyone who blocked his way. Residents also deliberately aggravated other residents by placing their wheelchairs in a position that obstructed those who were passing. This was often done just inside the door of the coffee shop or the station desk. These men would ignore all entreaties to move on, and finally a staff member or the coffee shop volunteer would be required to move them to allow others to pass.

Residents reacted strongly whenever their personal belongings were invaded by other residents. Several men said they would physically attack anyone they discovered touching their possessions. Although sometimes the intrusions were a deliberative search for cigarettes or candies, often, it was done by one of the mentally incompetent men who did not fully appreciate their actions. One resident developed a great hostility to two men whom he discovered going into his possessions. He would threaten them with his cane for any minor irritation. During the study, incidences of residents striking out at others were reported, and threats of violence were witnessed by the researcher, but no physical aggression was observed.

Some of the residents would react to other residents in a manner that demonstrated no respect for the human attributes of compassion and understanding.

This was most noticeable in the reaction toward the mentally incompetent men. Common considerations like freedom of movement were jeopardized. In these situations, the other resident was treated as an object with dehumanization of the person.

Resident-to-staff.

There were residents who referred to the staff as a means to get something done as opposed to an employee who was employed to care for them. In this situation, the staff were expected to wait on the men, not just provide care for them. Some staff members believed that many of the residents saw it as a woman's duty to look after men. In this situation, the men, who were veterans, believed that they had earned the right not just to be cared for, but to be waited on. Although staff acknowledged the importance of the veteran role, expectations for care were not always compatible.

At times, residents would attempt to manipulate staff to achieve their individual objectives. This was especially evident if the caregiver was new or relief staff. New staff would be tested by residents, with the resident often seeking additional assistance more regularly than required or establishing a more stringent schedule.

When residents interacted with staff in a dehumanizing way, staff members were treated as a servant or handmaiden. Residents expected care activities to be completed at their convenience and would manipulate the situation in order to achieve this end.

Staff-to-resident.

When individuals were treated as nonpersons, interactions did not demonstrate the simple human attributes of compassion, understanding, and kindness. In the dehumanized pattern of interaction the person was reduced to an object, a task, or a nonhuman life form. In this situation, the staff member saw the days assignment as tasks to be completed. These tasks were organized to be accomplished as quickly as

possible, and the individual needs of residents were not considered. Because the resident was viewed as an object, there was little attempt to avoid bodily exposure by the use of curtains and doors.

When a resident was treated in this dehumanized way, work was present-oriented, with little concern for the long-term effects of institutionalization and immobility. Walking residents was not done, and wheelchairs were used to transport residents more quickly even if they were capable of walking the required distance, and physiotherapy or occupational therapy sessions were missed if they interfered with ward activities.

When dehumanization occurred, normal human limitations were ignored. There was a loss of appreciation for what was normally considered appropriate behavior. Most staff attempted to make mealtime for the mentally incompetent residents pleasurable and relaxed by using table cloths, minimizing background noise, and sitting with the residents while they were being fed. Occasionally, this did not occur, and residents were given their food in amounts and at a rate that made chewing difficult. There was no attempt to make mealtime pleasurable, and the television or the radio was played for distraction of the staff rather than the enjoyment of the residents. In other aspects of care, there was a failure to appreciate the limitations of the resident, and staff would attempt to rush residents, often resulting in frustration for both staff and resident.

Residents would be ignored and treated as if they did not exist or were invisible. For instance, a resident, although directly in the line of vision of staff members, would not have his presence acknowledged. He would wait patiently to be addressed, often unsure if he was noticed or not. When the request was for an alleviation of a physical symptom (e.g., pain, indigestion, constipation) this resident would likely wait or interrupt the staff member. On other occasions, he would leave

without interacting with the staff. In one situation, a resident delivered a newspaper to the desk where two staff members were talking. He waited patiently directly in front of the staff, but neither staff member acknowledged his presence. Eventually, he left the paper and moved on.

Sometimes, staff would initiate an activity with a resident without explanation or warning, or else the staff would approach the resident with a rhetorical question. Residents who were in wheelchairs would be moved to alternative places, and decisions would be made without attempting to find the resident's wishes. Occasionally, the resident would respond to a rhetorical question appropriately, yet the staff person would not attend to the answer either deliberately or simply not hear it. For example, a staff member approached a resident in a wheelchair in one of the lounges, and as she unlocked the wheelchair and began pushing the man to his room, she asked if he wanted to go to bed. This man responded "Why do you give me a choice? I have no choice." This staff member showed no indication that his observation was even heard.

Interaction between staff and residents that was dehumanized was strictly task-oriented. The routine of the unit directed all interactions between staff and residents. Many times, the resident was ignored as if invisible or addressed in the form of rhetorical questions.

Staff-to-staff.

The resident was dehumanized when the plan of care was geared to task completion without consideration for individual differences. The need to finish the work overrode any particular need of a resident. Formal reports were rote, with staff only reporting what tasks were completed. This reporting treated the resident as the object of care rather than a person, even a stranger, who required assistance. Team

conferences were held to facilitate making the taped report, but no adjustment to the plan of care occurred.

Although breaches of confidentiality were not observed, it could be concluded that when there was no recognition of the person information would be told indiscriminately. As there would be no respect for the person, information concerning the individual would be deemed valuable only if it served the teller.

A large percentage of the residents had abused alcohol during their lifetimes. Stories told by the staff members about the men on the ward reflected continued alcohol abuse. Some of the incidents were confirmed by other staff and residents, but on other occasions, the stories were not verified. Stories would be told about the resident that would ridicule and discredit him, and these stories would create a negative attitude about the resident rather than establishing a context that would enable others to appreciate the resident's humanness.

When the resident was treated as an object, there was no attempt to understand the resident's perspective; rather, staff would create a situational context that reflected their own values and biases. One man regularly went out on his own for one or two hours several times a week. He explained to the researcher that while out, although he did have a beer or two, he was able to enjoyed the companionship of his old friends. Some staff interpreted his trips out as further alcohol abuse, and they even felt he should be expelled from the facility. Staff would make derogatory comments that demeaned the resident and often they did not accurately describe the situation.

Staff-to-staff interactions which dehumanized the resident were designed for the efficient and expedient completion of the tasks related to the job. Stereotypical expectations were expressed about the residents, some of which the researcher found little evidence to support. Stories were told that criticized, demeaned, or ridiculed the resident and were unrelated to any plan of care.

Relationship of Context and Interactions

Residents and staff members commented that increased interaction occurred between residents and staff in informal or recreational situations. Social events within the facility, such as the happy hours, would foster resident-to-resident communication. During these events, residents would deliberately sit by each other and initiate conversations. Similarly, recreational events that allowed staff to interact with the resident outside the traditional caregiver role allowed staff to see the resident in a different context In these situations, staff would enthusiastically share with each other resident response to specific situations. They would explain how a resident had noticed the birds chirping or how another man had leaned his head back to sniff the air. As one nurse explained it to the the researcher, "This [the outing] is a *natural* experience, something that they might have done before they were admitted to the unit. I think it helps them remember those times." Beyond the recreational and therapeutic value of such events, it was an opportunity for staff members to have a shared experience with the residents and consequently, it provided a common area of interaction outside the normal caregiving role.

Types of Interactions in Relationship to Privacy

How a staff member views the resident will determine how he/she defines privacy for the resident. Privacy is naturally respected when interactions involving residents and staff acknowledge the personhood of each other. Respect for privacy is respecting the individuality of each resident and acknowledging the personhood of each resident. Activities related to maintaining privacy are activities that in general demonstrate a respect for the individual. The dignity, self-esteem, and autonomous nature of the person is promoted and the personhood of the resident is reaffirmed.

In situations where the resident is denied his individuality and acknowledged only as a resident in the facility, the right for privacy is then defined only in the context of the role of resident. Respect for privacy is demonstrated as respect for the resident/stranger in the facility. Privacy is viewed only as institutionalization affects it and rules for privacy are incorporated into policies and procedures of institutional manuals. In the resident situation, the objectives of the caregiver take precedence, and privacy is invaded if care requirements for the resident or the needs of the institution are seen as more important. As a result, the autonomy of the resident is jeopardized, and ultimately, there may occur a loss of self-worth and dignity.

Finally, when the personhood of the resident is totally *ignored* and the resident is dehumanized, the right to privacy is denied. In this situation, there is no respect for the person, and the resident is treated as an object. Privacy is not considered and is violated. Table 1 contains a summary of the characteristics of each pattern of communication and the relationship each pattern has on privacy.

Table 1: Patterns of interaction in a long-term care setting: Relationship to privacy

COMMUNICATION ROUTE	PATTERNS OF INTERACTION: PERSONALIZED	DEPERSONALIZED (STRANGER)	DEHUMANIZED (OBJECT)
Resident-to-resident	*Caring behaviours* •anticipated needs of others •offered assistance or advocacy *Relationship* •friendship warmth, sharing, humour, reciprocal	•lacked involvement •formal superficial, cordial conversations trite	•ignored each other •no relationship courtesies ignored no acknowledgement of frailties
Resident-to-staff	*Appreciation of the person* •acknowledged in the total social context •mutual respect •sharing of personal information	•acknowledged in caregiving role •care rewarded or punished •employee/employer relationship	•acknowledged in task context •manipulation •servant/handmaiden relationship
Staff-to-resident	*Appreciation of the social context of the resident* •"care of the person" •bends rules/routines to allow for individual preferences •care is past, present and future oriented	*Interaction context is role-based* •"care of the resident" • bends rules/routines to accomplish care activities • care is present and future oriented • distant, professional	*Interaction context is task based* •"completion of the task" •unit routine is enforced •care is present oriented • invisible
Staff-to-staff	*Interactions about residents aimed at a personalized plan of care* •mutual goal setting between resident and staff •residents' confidences are respected •shared stories reveal the personhood of the resident	*Interactions about residents aimed at staff control over the plan of care* •resident input into the plan of care controlled •residents' confidences are shared by the staff •stories told for interest	*Interactions aimed at organizing and completing tasks efficiently/expediently* •shared stories criticize, demean or ridicule the resident
Relationship to Privacy	*Privacy is respected* •personal respect is conveyed naturally (inherent in relationship) •function of relationship	*Social norms of privacy are acknowledged* •ascribed rules of privacy are complied with	*Privacy is violated* •privacy not considered necessary or important

VI. DISCUSSION

This study was designed to describe privacy attainment and maintenance in a long-term care facility. The findings of this study indicate that interactions between staff and residents can be classified into three patterns: personalized, depersonalized, and dehumanized. Privacy violations occurred whenever there is any diminution of the personhood of the resident; thus, a discussion of personhood acknowledgement in a long-term care facility is included in this discussion.

The purpose of this chapter is to discuss the findings of this study in light of the existing literature on privacy and on humanizing care in long-term care facilities for the elderly. The material is presented within the following structure: 1) a discussion of findings; 2) implications for nursing practice; 3) a discussion of research methods; 4) suggestions for future research; and 5) a summary.

Discussion of Findings

An unique perspective for examining privacy in a long-term care facility emerged in this study. When staff and residents interacted in a way that did not demonstrate a respect for their individuality, the risk of privacy invasion increased. When there was dehumanization of the person within the relationship, there was no regard for privacy. Privacy was respected when the resident was acknowledged as an individual. Therefore, when there is respect for the individuality of the person, there is a respect for privacy.

The relationship between personhood, individuality, and privacy was first alluded to in the 1890 *Harvard Law Review* when Warren and Brandeis lamented the intrusion into their personal lives by "nosy social reporters". At this time, they described the offense as being one against the "inviolate personality." Legal writers

and philosophers have since supported a moral claim to privacy based on a general principle of respect for persons (Benn, 1984; Bloustein, 1964/1984; Reiman, 1976). They argue that intrinsic to the notion of personhood is the right to determine to whom thoughts, emotions, sentiments, and tangible products may be communicated. Any interference with this claim is an affront to human dignity because it threatens the individual's sense of uniqueness and sense of self. Bloustein (1964) clarified this relationship when he said:

> The man who is compelled to live every minute among others and whose every need, thought, desire, fancy or gratification is subject to public scrutiny, has been deprived of his individuality and human dignity. Such an individual merges with the mass. His opinions being public, tend never to be different: His aspirations, being public, tend always to be conventionally accepted ones; his feelings being openly exhibited tend to lose their quality of unique personal warmth and to become the feelings of every man. Such a being although sentient, is fungible; he is not an individual. (p.188)

For Bloustein, the danger of unrestricted access to the person ultimately creates in the person a loss of any sense of individuality. When a dependent relationship exists, as in institutionalization, there is a tendency for staff members to assume that to accomplish their role they need to have unrestricted access to the resident. The findings of this study indicate that whenever the individuality of the resident was ignored, thereby denying the personhood of the resident, protection of privacy was threatened. Lack of individual resident appreciation was a characteristic of depersonalized and dehumanized interaction between staff members and staff.

Depersonalization and dehumanization of long-term care residents have been described in numerous studies related to institutionalization (Berdes, 1987; Goffman, 1961; Gubrium, 1975; Kayser-Jones, 1981; Rosenhan, 1973). The world described

by Goffman (1961) in *Asylums* illustrates how the loss of privacy encroached on the sense of self in institutions:

> On the outside, the individual can hold objects of self-feeling–such as his body, his immediate actions, his thoughts and some of his possessions–clear of contact with alien and contaminating things. But in total institutions these territories of self are violated: the boundary that the individual places between his being and the environment is invaded and the embodiments of self profaned. (p. 23)

Although Goffman implied that the dehumanization was deliberate in order to create an environment that facilitated control, other explanations of this phenomenon have been offered.

One explanation to account for the dehumanization and depersonalization that occurs in the care of the aged uses exchange theory (Kayser-Jones, 1981). Due to their dependency on others for care, the institutionalized elderly are not seen as participating in a balanced social relationship. This is especially significant when the elderly are seen as not contributing anything in exchange (i.e., not paying directly for the service). As a result, the dehumanization and depersonalized treatment that is observed may be examples of negative sanctions brought against those who are in a nonreciprocal position. Staff members did feel that some residents did not appreciate the care which they received and many staff members wanted nothing more than a verbal expression of gratitude, such as a thank-you or a friendly smile. Small tokens of appreciation although received graciously were often viewed in the context of the relationship already established. If they were given by a resident who was labelled as demanding, these gifts were seen as a manipulative gesture; whereas, if they were given by a cooperative resident, the treat was accepted as a token of appreciation.

When depersonalization or dehumanization occurs there has been a loss of identity by the resident. Many of the situations that are associated with the loss of identity in institutions have been accepted as inherent in institutionalization. Loss of control, loss of relationships, and loss of privacy are three interrelated components that have been identified as leading to dehumanizing treatment in nursing homes (Berdes, 1987). Support for the above findings was evident in this study as personalized interactions between staff and residents allowed for control, encouraged relationships, and respected privacy. Similarly, in depersonalized interactions, the resident lost control, friendly interactions were discouraged, and there was an invasion of privacy. These three components do not function independently as each have a feedback effect on the other.

Control was demonstrated when residents were allowed to have an effective voice in their care as well as the general running of the facility. Such involvement needed to be genuine. Some residents expressed resentment that although there was a residents' council the input through this committee tended to be cosmetic rather than legitimate. Other residents were able to identify situations where their input was acted upon, such as, the addition of an extra phone on the unit for resident use. Personalized interactions allowed residents an opportunity to be involved in developing their own plan of care. These residents were able to direct their daily care and established routines. When interactions were depersonalized, the resident was given less opportunity to control his life and routines on the ward or decisions by the staff members would direct the plan of care for the resident.

Several factors have been identified that work against relationship formations between staff and residents. An initial conflict may occur because staff and residents may have different objectives. The primary objective of many staff is the completion of the physical tasks associated with the care of the residents, Gubrium termed this the

"bed and body work" of the unit. However, the residents' primary objective is to live as proper human beings (Gubrium, 1975). Although these two objectives need not be in conflict, in the present study depersonalization and dehumanization did occur when staff focused on completing the routine tasks while excluding the acknowledgment of the resident as an individual.

Depersonalization may reflect more role expectations than a conscious decision to control residents. Conflicts between the accepted norms of service and the conditions that work toward the establishment of intimacy between residents and staff have been identified. Detachment, affective neutrality, and universalism tend to be the accepted norms of service; whereas, particularism, affective expression, and reciprocity govern more intimate relationships (Noekler & Poulshock, 1984). Some staff members were critical of other staff members who provided extra service to residents because they believe such activities would spoil residents and ultimately make institutional life more difficult for them. Similarly, stereotypical expectations of residents based on preconceived ideas of institutionalized elderly and veterans often inhibited staff appreciating the particular characteristics of the residents. Some staff members expressed the belief that veterans expected to have everything given to them, and as a result, these staff members were reluctant to assist them even when their physical condition warranted some help.

Implications for Nursing Practice

A genuine respect for privacy is demonstrated by actions that confirm a respect for the resident as a person of worth and dignity rather than merely by following designated rules. Closing the curtains around a resident may create the impression of privacy for the staff member, but if the resident is not treated with respect for his personhood, no advantage is gained from the action. Privacy protection becomes a

function of the caregiver when a resident is totally dependent on others and unable to rely on his own resources to provide privacy maintenance. For the staff member who does not view the resident as an individual, privacy protection is conceptualized in the narrow perspective of behaviors that protect privacy. To define respect for privacy in this wider context of respect for the individuality of the person reveals a broader perspective for privacy maintenance. By identifying depersonalization as an antecedent to privacy invasion, actions that will ultimately lead to privacy respect can be identified. These actions should include opportunities for both staff members and residents to appreciate each other as individuals.

In order for a genuine respect for the individuality of the person to occur, both staff members and residents must appreciate each other beyond the immediate interaction of care activity. This may require that some staff members and residents reformulate the role expectations of staff to include activities outside the "bed and body" work. Staff members need to help residents get to know them as individuals. This includes introducing themselves daily to their assigned residents, by wearing name tags that clearly display their name, by sharing self and by providing individualized care. On the other hand, residents also need to recognize staff members as individuals. In this study some residents mistakenly identified staff turnover as the reason they were unable to learn staff names. Smaller units also reduce the number of staff that each resident are in contact with and thus facilitate recognition.

Opportunities to interact outside the role of caregiver should also be promoted. Outings, special events, and celebrations allow both staff and residents to participate in an informal situation. Such activities allow both residents and staff members to see each other in a different perspective.

Similarly, relationships between residents need to be fostered. Admission to a long-term care facility disrupts established friendship patterns, and formulating new

relationships in institutions often proves difficult (Noekler & Poulshock, 1984). Residents have been found to prefer open wards over any other type of institutional accommodation (Kayser-Jones, 1989). This has been interpreted as the need for companionship being greater than the need for privacy. In order to consider privacy in the context of respect for the individual, it is necessary to understand that residents need to interact with others in order to maintain their sense of identity. There is a difference between being left alone and being left out. When the former is the choice of the resident, then the resident has some semblance of privacy. For example, an individual who has been ship-wrecked alone on a deserted island has no privacy because the alternative does not exist. So the resident who is alone in his room has no privacy if he has no opportunity to interact with others in a way that promotes his identity to others. The presence of others by providing a milieu to test one's identity proclaims it authenticity.

Avoiding interaction with others has been identified as a privacy maintenance behavior (Schuster, 1974). Unfortunately, in some situations, this may work against privacy. Ironically, by creating the situation of non-involvement, the resident does not become respected as a person and thus privacy respect is based only on the predetermined norms and rules and is not based on a genuine knowledge of the individual. Interestingly, increasing interaction may ultimately increase the privacy of the resident; therefore, situations that give staff and residents permission to move out of their perceived roles will break the norm of silence that is often observed in long-term care facilities.

Many residents are unable to actively protect their own privacy due to physical or cognitive impairments. It becomes the responsibility of the caregiver to provide care which demonstrates a respect not just for the person now known but for the person of the past. As Gael Knepfer says; "They [the elderly] need the nurse to guard and

preserve their personalities, their memorabilia and personal rituals, the symbols of their lives that remind them of who they were and are" (p. 163). It is here that respect for privacy moves beyond the realm of purely physical or bodily privacy and captures the personal element that reflects the individual. The pictures on the corridor walls revealed men who were once strong and independent. Their stories told of life events that were unique or commonplace, but these stories revealed a part of the person that now was dependent on others. Respect for privacy is to respect the person revealed in these pictures and stories.

Many individuals who enter the health care system automatically become a part of the educational experience for health care workers. However, when a patient becomes the focus of a teaching session, there is a risk that the patient will be treated merely as an interesting case. Focusing only on the condition and not attempting to acknowledge the person is part of the depersonalizing process. Similarly purely observational experiences that are often part of educational programmes for health care workers should only be included if the personhood of the patient or resident is respected. Otherwise such experiences are depersonalizing and may even be dehumanizing and thus an invasion of privacy.

Discussion of Methods

This study examined the concept of privacy inductively; therefore, privacy was not defined for the study prior to data collection. Data from the facility were collected from a broad perspective, and later, privacy was extrapolated from this information. The use of the observational method allowed the researcher to appreciate the complexity of the concept of privacy and capture the interrelatedness between individuality, personhood, and privacy respect. Through participant observation, the dynamics of

privacy maintenance were captured and the important antecedent of respecting the individuality of the person was identified.

The use of participant observation to collect the data created an obvious dilemma in the study. Continuous observation could be perceived as an invasion of privacy. Consents were obtained from each resident either directly from those who were able to give permission or indirectly from the official guardian of those who were deemed mentally incompetent. This acknowledged the personhood of each individual. These data were considered an extension of the resident and treated in a confidential manner. The researcher wore a name tag that clearly stated her role on the unit as a nurse researcher. The residents were constantly reminded of her purpose on the unit. Observations of personal care were carried out only with the permission of the resident and/or the staff member. Even with these precautions, the researcher did feel like an intruder on occasion and wondered if her own actions were not as depersonalizing as any she was observing on the unit.

The success of the data collection depended on accurate observations of the authentic situation of the ward. All staff and residents were receptive to the researcher. The role of the researcher was that of a non-participant observer; therefore, all observations were made without judgement at the time of data collection. Later in data analysis, some of these observations were evaluated in light of the categories that were emerging. This had the potential to create in the researcher a feeling of disloyalty to both the staff and the resident who may have shared with the researcher yet received no immediate feedback that the comment or observation was perceived as depersonalizing or dehumanizing. Although some of the staff and residents were used as secondary informants and were given the opportunity to explain their perceptions of the situation, many of the participants did not have this opportunity. Similarly, some of the depersonalizing behaviors were precipitated due to conformity to explicit or implicit

expectations of the institution. Although the researcher was able to appreciate these circumstances, the final conclusions could not condone the actions.

Suggestions for Future Research

Respecting the individuality of the resident was identified as an important antecedent to respect for privacy in this study. Further research is required to identify critical elements of privacy so that it may be better distinguished from other related concepts such as autonomy and modesty.. Further observations of the effects of varying levels of dependence, age, gender, or context of privacy loss would provide further insight in the variables affecting privacy.

Further research is necessary to examine the relationship of a sense of identity and privacy. For example, a hypothesis arising from this study and needing testing is: Do people with a strong sense of identity have a greater sense of privacy than those people who have less of a sense of identity?

A longitudinal study examining changes in privacy maintenance behaviour for individuals who are admitted to long-term care facilities would be beneficial in examining what effects the various characteristics of total institutions have on privacy maintenance.

Intrinsic to present-day society and to this study is the assumption that privacy is important to individuals, yet there has been no investigative studies that suggests this assumption is true. A phenomenological study to examine the experience of individuals who are deprived privacy would describe the lived experience of privacy loss and contribute to this discussion.

A limitation of this study was that all the subjects were male and veterans who had been in active service overseas. This experience may have changed their expectations for privacy. Comparison studies could use such an exclusive population

to compare privacy behaviours with groups who were not subjected to such enforced communal living.

SUMMARY OF THE STUDY

In this study privacy attainment and maintenance in a long-term care facility was examined. The existing literature on privacy tends to be descriptive and non-investigative. Although some direction for care could be derived from the available literature, privacy attainment and maintenance for individuals who were dependent on others for care was not adequately described. In order to address privacy attainment and maintenance for the long-term care resident, the method of interpretative ethnography was used. Participant observation and interviews were done over a six month period at a long-term care facility.

The findings of this study indicate that interactions between residents and staff can be classified in three different ways: personalized, depersonalized, and dehumanized. When the interaction is *personalized*, the uniqueness of the individual is addressed. Residents would demonstrate caring behaviors for other residents such as anticipating need and offering assistance. They would acknowledge staff members as more than just caregivers with interactions reflecting an appreciation of their life beyond the facility. Staff interaction with the resident would recognize not just his present social context, but his life patterns prior to admission. This past would be recognized, not in an evaluative manner, but as it affected his expectations and life in the facility. Wherever possible, the resident was an active participant in planning his care. Respect for privacy was inherent in this relationship.

When the interactions were *depersonalized*, the relationship no longer reflected an appreciation of the person; instead, it was structured by the social context of the institution. The relationship showed the characteristics of people who are strangers.

There was a lack of involvement between residents, with superficial communication lacking any sincere display of interest. Staff members interacted within the context of their role as caregivers and avoided a more personal level of interaction. Planning was done for the resident and input was controlled to reflect the expectations of the staff members. Respect for privacy at this level was mechanical, with ascribed rules and expectations directing privacy maintenance.

When the interactions were *dehumanized*, common courtesies were ignored, and unless there was a definite need to interact, residents and staff treated each other as if invisible or as objects. Interactions that did occur were task-based. Care was done to the resident as if the person was an object. As the individual was not perceived as human, no attempt was made to acknowledged their need for privacy. Privacy norms were largely ignored.

To assist residents to attain and maintain privacy, it is necessary that staff and residents acknowledge the personhood of each other. Such a process is facilitated when it is reciprocal; therefore, the responsibility should be shared by both staff members and residents. Yet, many of the accepted norms of institutionalization work against building relationships between residents and between residents and staff members. Some of the lack of involvement has been explained as an attempt to guard privacy, yet when this is done by isolating himself/herself from those who share the environment, it may result in decreasing quality of life. A respect for privacy is a respect for the uniqueness of each other, and this can only be appreciated when residents and staff know each other beyond the caregiver role.

The nebulous and dynamic nature of privacy is difficult to define and describe. Definitive answers to describe the essence of privacy have eluded social scientists, philosophers, and legal writers. An individual's expectation and experience of privacy is influenced by both personal and environmental factors. Because privacy is context-

bound, the experience of privacy for an individual living outside a long-term care facility is both quantitatively and qualitatively different from the individual who is institutionalized and dependent on others for some aspect of care. Conceptualizing privacy as respect for the individuality of the person acknowledges these variations and facilitates providing care which will ultimately enhance privacy protection.

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APPENDIX A

LETTER OF EXPLANATION TO PARTICIPANTS

A Research Study on Privacy

I would like to invite you to participate in a study on privacy. During the study I will be spending time on the ward observing how residents keep their privacy and talking with residents about privacy.

I am a nurse but presently I have returned to the University of Alberta for further studies. This research is important to help people respect your privacy better.

I will be available to answer any questions you may have. Thank-you very much for your help with this important research project.

Yours Sincerely

Mary Applegate, Graduate Student
University of Alberta
Faculty of Nursing
3-120 Clinical Sciences Building
Edmonton, Alberta, T6G 2G3
Phone 492-8233

APPENDIX B

RESIDENT INFORMED CONSENT FORM

PROJECT: Privacy Attainment and Maintenance for the Long-Term Care Resident

I, _____ agree to be a volunteer in the research project about privacy of residents in this facility.

I understand that the researcher will watch and keep notes about my daily activities and talk with me about my privacy. These talks will be tape recorded and what is said will be typed.

I understand that I am free to refuse to answer any question and I am free to ask any questions. I also understand that I may withdraw from the study at any time without penalty. I simply tell the researcher, or a nurse, of my decision to withdraw.

I understand the researcher will remove my name from the tapes, typed information, and notes. This information will be kept in a locked cupboard and shared only with my teachers. If this information is used for another study, that study will be reviewed by an ethics committee.

I understand that the information from this study may be published or presented at conferences but my name will not appear or be mentioned.

I understand that there will be no harm or benefit to me by participating in this research.

I have been given the opportunity to ask any questions I have about the research and all such questions have been answered to my satisfaction.

I have crossed out any part of this form with which I do not agree.

Participant	Witness	Researcher

Date

Researcher: Mary Applegate Phone 492-8233
Graduate Student, Faculty of Nursing
Under the supervision of Dr. J. Morse, Phone 492-6250
Faculty of Nursing, University of Alberta

APPENDIX C

VERBAL CONSENT FOR INTERVIEW (TAPE RECORDED)

May I turn on the tape?

My name is Mary Applegate, and you will recall that I am doing a research study about privacy in a long-term care setting. As a part of this study, I would like to talk to residents, and to tape record these conversation.

The interview will take about an hour. At any time you do not wish to answer a question, you may refuse to do so. You may stop the interview at anytime you wish.

The discussions on the tapes will be typed, and what you say will be shared with my teachers, but they will not know your name.

If we use the information you tell us for another study, the study will be approved by the ethics committees, and your identity will be protected.

Do you have any questions?

Would you be willing to talk to me?

(This recorded consent will be duplicated onto a separate tape kept tor this purpose)

APPENDIX D

LETTER OF INFORMATION TO GUARDIAN OF RESIDENT

Date
Address of facility

Dear _____:

I am writing to let you know that a study will be conducted in the (*name of facility)* over the next six months. The research will be conducted by Ms. Mary Applegate, a registered nurse and graduate student. The purpose of the study is to learn how residents value privacy, and Ms. Applegate will be observing and talking to some of the residents. I wanted you to know about the study, as your relative may be a participant, if he or she agrees.

It is important to note that Ms. Applegate is a graduate student at the University of Alberta, and not a hospital employee. However, the project is being conducted with university and hospital approval, and only those residents who wish to be a part of this study will be included.

If you require further information, please call me at *(Telephone number of coordinator).*

Yours truly

Coordinator, *(Facility)*

APPENDIX E

LETTER TO PUBLIC GUARDIAN

Date

Public Guardian,

Dear Sir/Madam;
A study has been given approval by the appropriate ethical committees for Ms. Mary Applegate to conduct a project on patient privacy on *(unit and facility name)*
Those residents who wish to participate will be observed, and only those who are not confused may be interviewed. Any patient may withdraw his consent at any time.

If the field notes and observations obtained from this study are used in a subsequent study, please be assured that the proposal will have been subject to the scrutiny of the appropriate ethical committees to ensure that patients' rights are protected.

The following residents are listed under your guardianship:

If you require further information or do not wish these residents to participate, I may be reached at *(telephone number of coordinator)*.

Sincerely,

Coordinator, *(facility name)*

cc. M. Applegate

APPENDIX F

STAFF INFORMED CONSENT FORM

PROJECT: Privacy Attainment and Maintenance for the Long-Term Care Resident

INVESTIGATOR: Mary Applegate Phone: 432-8233
SUPERVISOR: Dr. J. Morse Phone: 432-6250

The purpose of this research project is to describe how residents in a long-term care facility attain and maintain privacy. The research is being carried out as part of the master's programme in nursing at the University of Alberta.

An important part of the research will be the activities, comments and insights of care givers of these residents as well as the residents themselves.

I will be on the ward participating as an observer for several months. During this time you may be invited to be interviewed (up to three times) to give your views into how residents attain and maintain privacy. These interviews will be at a time of your convenience and should not be longer than 30 minutes each. The interviews will be taped recorded and later transcribed. The typed transcriptions will be identified by a code number—your anonymity will be protected. All field notes will be kept in a locked cabinet. The final report containing anonymous quotations from these interviews will be available at the completion of the project.

There is a possibility that the data may be used in the future for another project. If this occurs, then the second study will be reviewed by the appropriate ethics committee, and again, your identity will not be associated with the data. Data will be destroyed when it is no longer required.

There will be no direct benefit for participating in this study, but it is hoped that the information gained will be useful to those caring for residents in long-term care facilities.

THIS IS TO CERTIFY THAT I, _____HEREBY agree to participate as a volunteer in the above named study.

I understand that there will be no health risk to me resulting from my participation.

I hereby give permission to be interviewed and for these interviews to be taped-recorded. I understand that the information may be published, but my name will not be associated with the research.

I further agree for the researcher to make observations associated with ward activities. These observations will also be coded to insure anonymity.

I understand that I am free to not answer any question during the interview and to withdraw my consent to participate in the research at any time during the study without penalty.

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

Please cross out any part of this form that you do not agree with.

_____ _____ _____

Participant Witness Researcher

_____

Date